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ABSTRACT

Numerous factors influencing health status and health care in Mexico are reviewed in this paper. Part I covers socioeconomic influences including agricultural and land tenure patterns, oil production, population growth rate, and the extent of poverty. Part II discusses the political environment, emphasizing the effects of politics on strategies for rural health. Topics include the political elite and their influence, dependency on the United States, pressure groups of the political left and right, and attempts at governmental reform. Part III compares Mexican health needs with those of other developing nations. Discussion touches on developmental stages of health system development, historical diffusion of western health care models, and characteristics of rural underdeveloped areas in developing nations. Numerous health care problems are cited, e.g., limited access to care, lack of public health policy, class bias in health services, expenditures for high technology rather than public health, and maldistribution of human resources due to maldistribution of wealth. Part IV summarizes the status of health care in Mexico including health indicators, health care delivery systems, rural conditions, vertical organizations and health campaigns, health decisions as broad cultural expressions, and women and showmen in medicine. (JHZ)

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MEXICO; THE SOCIO-ECONOMIC AND CULTURAL
ENVIRONMENT FOR HEALTH

by

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Field Trip on Health in Mexico - Summer 1983
May 1983

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MEXICO; THE SOCIO-ECONOMIC AND CULTURAL
ENVIRONMENT FOR HEALTH by Moses Stambler

There are wide environmental parameters involved in understanding what is taking place in Mexican health, especially the rural health area. These are included in this paper on health in Mexico.

In Part I, on the socio-economic environment, it has been necessary to look at the petrol situation, population needs, the poor, and Mexican agriculture and land tenure patterns.

The political environment too has been developed as a significant environmental factor for focusing on rural agriculture. Political needs, elites, tensions and fears, and pressures from the left and right provide the constraints and parameters within which the government plays out its strategies for rural health. This material is covered in Chapter II.

In Part III, Mexican health needs and realities have been placed in the comparative context of other developing nations, and areas have been pinpointed where health needs are unique, and/or typical of developing nations.

In Part IV on Health Care in Mexico, Mexican health indicators, organization, rural conditions and problems have all been noted. Also, noted is the tripartite health system of Mexico which meets health needs of its different constituencies within a historically changing framework of power relationships. Patterns of class bias in society are reflected in the types and levels of health delivery services available to the people.

Institutions are part of an organic whole. The intrinsic environment clearly forms parameters for Mexican health development. The extrinsic environment however, impacts it as well. The choices, function and are limited by these constraints.

MEXICO: THE SOCIO-ECONOMIC AND CULTURAL ENVIRONMENT FOR HEALTH

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INTRODUCTION

When I started research and writing for this paper on Mexican Health, I planned to use the rural area as a focal point. The environment of the rural area was to be described and analyzed in terms of its impact and interrelationship with rural health. However, as the research task developed, I found continuously expanding parameters necessary to understand and explain what is taking place in Mexican health, especially the rural health area.

In Chapter I, on the socio-economic environment, it has been necessary to look at the petrol situation, population needs, the poor, and Mexican agriculture and land tenure patterns.

The political environment too has been developed as a significant environmental factor for focusing on rural agriculture. Political needs, elites, tensions and fears, and pressures from the left and right provide the constraints and parameters within which the government plays out its strategies for rural health. This material was covered in Chapter II.

In Chapter III, I placed Mexican health needs and realities in the comparative context of other developing nations, and attempted to pinpoint areas where its health needs are unique, and where these health needs are typical of developing nations.

-v-

In Chapter IV on Health Care in Mexico, I noted Mexican health indicators, organization and rural conditions and problems. Also, how the Mexican government has a tripartite system to meet the health needs of its different constituencies within a historically changing framework of power relationships. Patterns of class bias in society are reflected in the types and levels of health delivery services available to the people.

If there is a conclusion possible at this stage, it is the organic nature of institutions. The intrinsic environment clearly forms parameters for Mexican health development. The extrinsic of environment however, impacts it as well. The choices are limited by these constraints and the time is running out for democratic reform.

I-1

I. THE SOCIO-ECONOMIC ENVIRONMENT FOR MEXICAN HEALTHA. ECONOMIC ENVIRONMENT

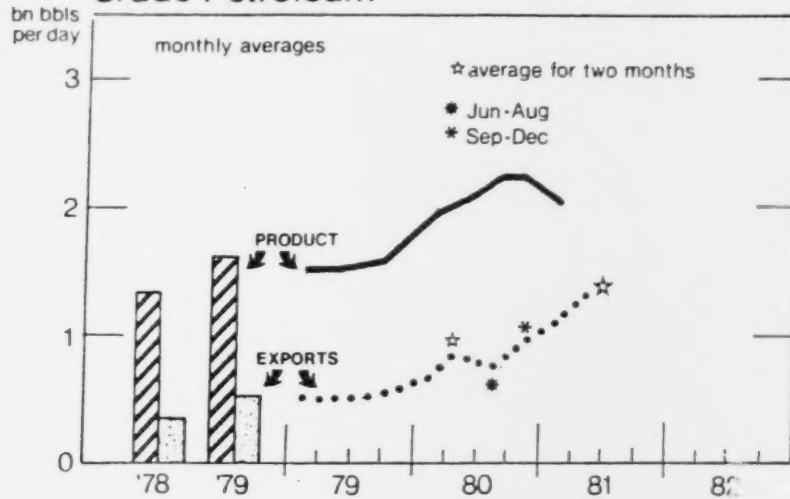
The socio-economic environment in Mexico, as with other oil rich developing nations, has been impacted by the drastic fluctuations between oil scarcity and oil glut. The huge oil-fields discovered in Mexico gave her greater accessibility to world markets, but also served to hook the Mexican economy on oil production. As noted in a recent issue of U.S. News and World Report, (Mexico's Poverty, 42).

Billions in petropesos overheated a shaky economy that was incapable of absorbing it. Instead of trying to hold down inflation, the government rushed headlong into a program of rapid development. Huge amounts of capital were borrowed abroad at high interest rates. The result, when the bottom dropped out of the oil market, was an economy that lay in ruins by mid-1982.

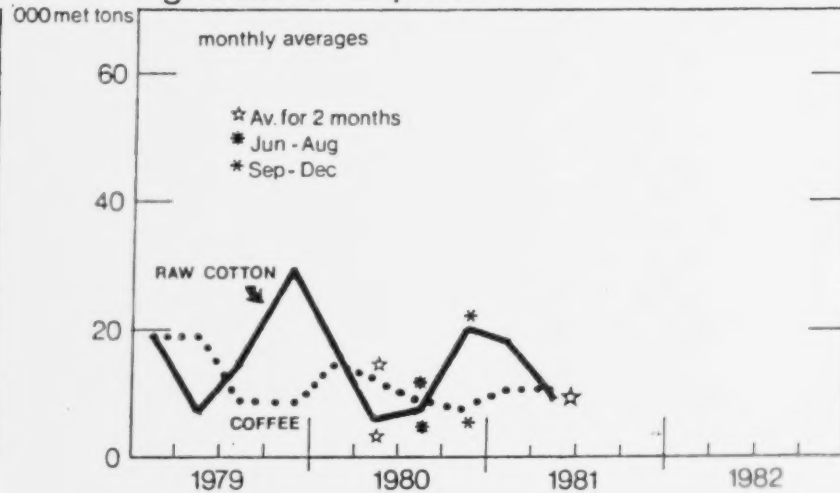
Foreign debt exceeds 80 billion dollars, much of it in short-term loans. Interest on foreign liabilities totals 17 billion. Inflation for 1982 reached 100 percent. Graft and corruption escalated as billions in oil revenue passed through official hands. The peso, 26 to \$1 in 1981, now is close to 150 to \$1, making Mexico a bargain for vacationing Americans.

Economic Trends in Mexico

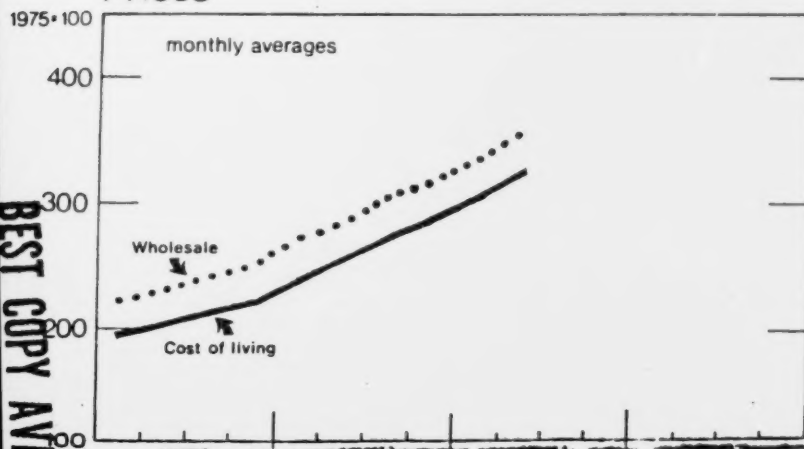
Crude Petroleum



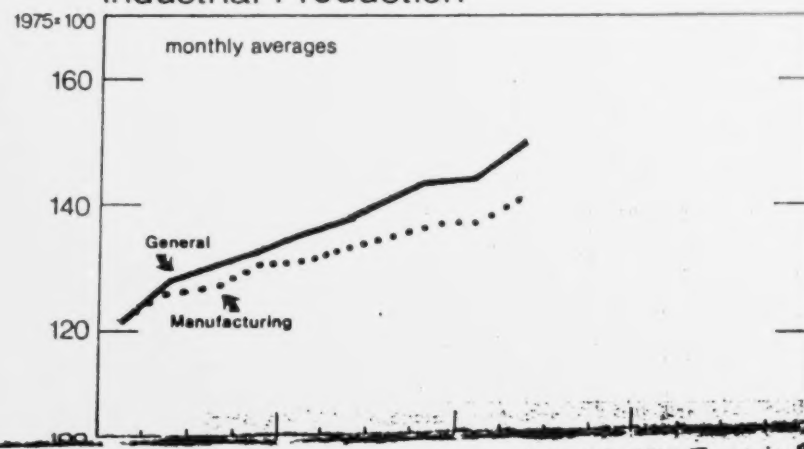
Agricultural Exports



Prices



Industrial Production



QUARTERLY ECONOMIC REVIEW
MEXICO

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Economic indicators of Mexico suggest the major economic forces which underly the health problems and changes faced by the population in both urban and rural areas.

A graphic illustration of Economic Trends in Mexico shows increased crude petroleum production, declining agricultural exports, increase in monthly prices and in industrial production (Chart I -3). (Chart from the Quarterly Economic Review of Mexico, 1981)

I-4

The pace of change is so rapid and the consequences so socially significantly that it is difficult to rely on two year old data as providing a realistic profile. Even 1983 data becomes rapidly outdated.

As noted in the March 1983 U.S. News & World Report indicators (See Table I-5), population has increased, so too have inflation and unemployment, imported food, external debt, and the peso exchange rate. On the positive economic side, total economic output has increased (although a large share is due to petro-dollars, per capita output has increased and there has been a slight decline of infant deaths (Mexico's Poverty, 42).

I-5

Key Indicators of A Troubled Nation

	Mexico 10 Years Ago	Mexico Today
Population	54.3 mil.	73.1 mil.
Inflation rate (per year)	5%	100%
Unemployment rate (including under- employment)	Unknown	50%
Food as share of imports	6%	17%
External debt	\$4.8 bil.	\$80.1 bil.
Exchange rate (pesos per U.S. dollar)	12.5	150
Total economic output	\$41 bil.	\$239 bil.*
Per capita output as share of U.S. per capita output	13%	27%*
Infant deaths per 1,000 live births	61	56

*1981 figures, latest available.

USXNR—Basic data: U.S. Dept. of Commerce, International Monetary Fund, Population Reference Bureau.

U.S. NEWS & WORLD REPORT, March 7, 1983

I-6

B. POPULATION & SOCIAL NEEDS

The pressure to meet human needs in Mexico is increasing
(Mexico's Poverty, 42).

While new President Miguel de la Madrid imposes drastic austerity measures, a huge backlog of human needs is growing larger for Mexico's 73.1 million people. Food, housing, clothing and jobs are in increasingly short supply for the masses. Misery is spreading in the countryside.

Making things worse is rapid growth of the population. By the year 2000, the country will have 100 million people. ... 42 percent of the population is now 15 or under.

I-7

Unemployment prior to the oil boom which ran at approximately 40% has now reached approximately 50%, with a potential of 1 million more Mexicans facing unemployment by the end of 1983 (Mexico's Poverty, 42).

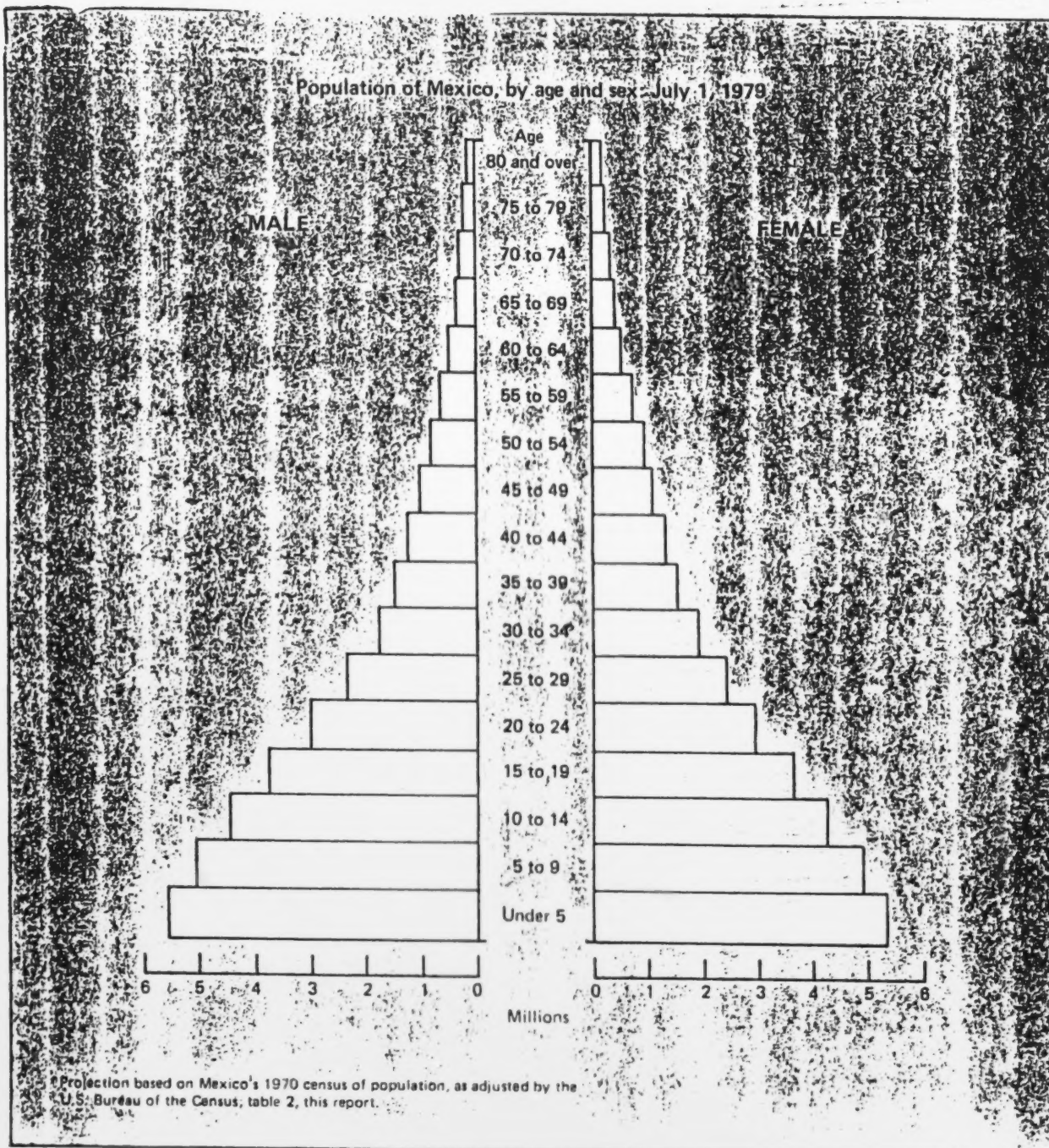
The social and economic problems of Mexico are complicated by demographic pressures (Bailey, 358). (See Table I-3)

Mexico, like Brazil, combines a high growth rate (about 3.0 percent) with a large base (about 70 million) to yield troublesome results: (1) its population will almost double by the turn of the century; (2) about half the population is under 16 years of age, with the obvious implications for nutrition, education and employment; (3) pressures on land are mounting, leading to a further "pulverization" of holdings.

The population explosion has resulted in numerous socio-economic problems for Mexico (Bizzaro, 371).

Poverty, hunger, malnutrition and disease are also the results of one of Mexico's most difficult problems: the population explosion. The high birth rate, in turn, has aggravated unemployment. Forty percent of the nation's youth cannot find work, while close to 50 percent of the Mexican workforce is either unemployed or underemployed. These percentages are not likely to decline, because the government has difficult finding work for the 700,000 who enter the labor force every year. Although per capita

I-8

County Demographic Profiles,
Mexico

I-9

income is more than \$1,200 a year, the average annual income of the Mexican worker is \$220 in the cities and around \$80 in the countryside. If a family spent this all on food, it would have far less than enough.

Because of overcrowding in the rural sector, many peasants are migrating to the cities, straining the resources of urban areas. The poor performance of the country's agricultural sector is mostly to blame. Mexican agriculture contributes less than 10 percent to the gross domestic product but employs an estimated 33 percent of the labor force.

The comparative table of Latin American (Table I-5) including Mexican indicators suggest that Mexico has a low agricultural product as a percentage of its GNP (16.1%), a young (under 15) population (46.3%) a high rate of population increase (3.5%), and a large rural population (38.2%).

I-9

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I-10

Table 1. Area and selected demographic indicators of eight Latin American countries in recent years

Country	Area, Square kilo- meters	Popula- tion — midyear estimate	Popula- tion — Density	Popula- tion — Percent of annual increase 1963-1968	Popula- tion — Percent under 15 years 1968
		1968	1969		
Argentina	2,776,889	23,617,000	9	1.5	29.7
Brazil	8,511,965	88,209,000	4	3.0	42.8
Chile	756,945	9,351,000	13	2.4	40.0
Colombia	1,138,914	19,825,000	18	3.2	46.6
Cuba	114,524	8,074,000	72	2.2	37.3
Guatemala	108,889	4,864,000	46	3.1	46.6
Mexico	1,972,546	47,267,000	25	3.5	46.3
Peru	1,285,216	12,772,000	6	3.1	43.3

Table 2. Indicators of age composition, urbanization, ethnicity, and literacy in the populations of eight Latin American countries in recent years (in percent)

Country	Under 15 years 1968	Rural 1970	American Indian	Literate
Argentina	29.7	22.4	0.6	91
Brazil	42.8	52.2	1.5	60.5
Chile	40.0	29.4	3.2	83.6
Colombia	46.6	44.1	1.6	72.9
Cuba	37.3	38.7	—	78
Guatemala	46.6	69.9	53.6	53.6
Mexico	46.3	38.2	8.8	62.2
Peru	43.3	50.8	46.7	61.1

Table 3. Selected economic indicators of eight Latin American countries in recent years

Country	Gross national product (GNP) per capita (in dollars) 1968	Gross agricultural product as percent- age of GNP 1963-1965 average	Economic active population (in percent)
Argentina	600	16.5	37.6 (1960)
Brazil	291 (1967)	29.0	32.3 (1960)
Chile	518	11.1	32.4 (1960)
Colombia	301	46.6	29.4 (1964)
Cuba	518	—	33.8 (1953)
Guatemala	297	31.2	33.1 (1964)
Mexico	553	16.1	26.9 (1970)
Peru	268	23.0	31.5 (1961)

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I-11

Overcrowding

There is a great deal of overcrowding in both rural and urban areas,
a (Bizzaro, 86-87)

... consequence, in large part, of the slow rate of agricultural output. Because of heavy investments on the part of the government and the private sector in oil and industry, agricultural production has declined since 1976 to a rate of only 2.5 percent (from 5 percent annually), and so has farm work. Migration to the north has served as a safety valve by draining potential unemployment from Mexico's urban and rural areas.

There is a moderate degree of illiterary in Mexico (although not as high as India's 75% figure). Alisky notes (Alisky, 366),

The 1980 census revealed that 28 percent of Mexico's adults are functionally illiterate. In 1975, when that percentage was even higher, the government decided not to rely so much on printed materials to promote family planning but to utilize radio, Mexico's principal mass medium. Some 95 percent of Mexican families had radios in daily use, and 6 million television sets drew 30 million viewers daily.

C. MEXICO'S POOR

Thus far the oil output has not been able to correct Mexican social problems. The nation has had a long and continuing problem of poor education, poor communications, in efficient bureaucracy and political corruption (Bizzaro, 373).

I-12

Of the nearly 70 million Mexicans, less than 5 percent live in luxury; another 20 to 30 percent enjoy the relative ease and comfort of the middle class; and the majority, more than 60 percent, struggle for survival. In the countryside, three-fourths of the population cannot be said to live in "homes" at all, crowded into one-room shacks, often as not on bare earth, and without water or sanitation. The urban poor suffer also...

Mexico has a booming population of young people under 15. At least half of the Mexican people (35 million) live at the lower, frayed end of the economic spectrum or outside the economy - the landless peasants, the migrant workers, the urban jobless, the homeless, the Sierra Indians, the wandering beggars, the sickly prostitutes, and the nameless uneducated who are "unemployed or "unemployable." Figures released in September 1980, by the Banco Nacional de Comercio Exterior (the government's Foreign Trade Bank) showed that, whereas in 1958 the richest 5 percent of the population had an income 22 times that of the poorest 10 percent, 20 years later the gap had more than doubled. Things were worse in the countryside.

The poverty conditions of Urban Mexico are noted by Alisky (Alisky,

369)

A majority of Mexicans remain ill housed, ill clothed, and ill fed not only because a rapidly increasing population dumps additional potential workers into the job market faster than the economy can expand to absorb them, but also because of uncontrolled urbanization, the crowding of too many citizens in some regions, leaving too few in others to utilize resources appropriately. Demographic disequilibrium strains distribution and communication facilities.

I-13

Half the republic's citizens live in 14 percent of the national territory, the central region or Valley of Mexico, with industries jammed into the metropolitan areas of Mexico City (and the adjacent state of Mexico), Monterrey and Guadalajara, despite vigorous government programs to decentralize industry through tax incentives, government investments, and public corporation branch expansions...

Major Mexican cities are urbanizing at a rate of at least 6 percent a year, although local and federal officials often cannot accurately measure the annual rate of increase. They rely on data about inner-city slums and government housing projects, but lack significant information about the ever-growing squatter settlements that ring each metropolitan area. Wooden, cardboard, and tin huts, without running water or plumbing, are slapped together from building scraps by those who live in vacant lots. These arrivals from the countryside seek non-existent unskilled jobs.

For the rural campesino going to improve his lot to the city area, there are many social and health problems (Bizzaro, 372).

... he has few skills and little or no education. He usually ends up in a slum, with the desperately poor, the uneducated and the politically unorganized, in a small city of filth, perversion and prostitution. About 750,000 campesinos go to Mexico City each year looking for work. In fetid Netzahualcoyotl, a slum of 2.6 million people that grows like a tumor on the outskirts of the capital, clouds of smoke from burning garbage make lung congestion almost epidemic. Contaminated water adds to the filth and contributes to a death rate of more than 50 percent among small children. Other urban areas, like Monterrey and Guadalajara, experience similar conditions. The combined results of internal migration are overwhelming unemployment in the cities and joblessness in the countryside.

I-14

The poverty condition of many Mexicans also leads to problems of hunger and malnutrition (Mexico's Poverty, 43).

The government insists it is trying to protect prices of basic foods. Yet malnutrition and hunger are growing. Last August, when the previous government suddenly allowed the control price for tortillas - thin, flat corn cakes - and bolillos - small rolls - to rise 100 percent, there was immediate suffering in the countryside.

Living conditions have since deteriorated even further. Workers say it grows more difficult daily to clothe and feed their families. A laborer with two children who gets the minimum wage of 450 pesos - about \$3 - a day, complains: "Meat and milk are too expensive for us. We get along on tortillas and beans." Another says his family eats poorly for days so that they can splurge occasionally and buy a piece of meat.

The unemployed spend their days looking for odd jobs. "Those of us who are still working will take a plate of food every now and then to a jobless family," a taxi driver notes.

Despite the poverty conditions, there is less money available for social services (Mexico's Poverty, 42-43)

Taxes up, subsidies down. The austerity program calls for a cut in the federal budget from 16 percent of gross national product in 1982 to 8.5 percent in 1983. Taxes have been raised on almost every aspect of Mexican life and subsidies cut drastically.

The government hopes to hold the inflation rate at 55 to 60 percent in 1983, but it could hit 75 percent. Prices for food, clothing, gasoline and other goods keep shooting up. Wage hikes lag, and construction is at a near standstill.

I-15

In Mexico, government is the engine of development. Last year, official spending made up as much as 40 percent of all investment in the economy. With spending now halved, public investment in the system will be reduced accordingly.

The private sector, which always follows the government's lead, will also be cut back, as will imports needed for production. As a result, the economy will slow even further.

There have been attempts to cope with the poverty situation (Bizzaro, 371).

To alleviate the conditions of the marginados, the people on the fringe of society, Lopez Portillo has organized an umbrella organization known as COPLAMAR, charged with designing an integrated approach to rural poverty. Its budget over three years has been around \$500 million, and its aim has been to give the rural poor access to health clinics, schools and regular food supplies.

D. CHANGING SOCIAL CONDITIONS AND STRUCTURE

The poverty conditions which exist in Mexico however should not one to an understanding of the tremendous progress that being made in terms of national development and personal/community achievement. One indicator and way of evaluating society is "social mobility," and this area shows impressive change. Its one party democracy is able to maintain relative peace at a time of great social pressure and change (Wilkie, 584).

I-16

Mexico has worked out a series of accommodations that are so ingrained in Mexican outlooks and traditions that they themselves define the uniqueness of the Mexico governmental system. It is not the political but the social system that is in transition, as evidenced in the growth of the middle class in Mexico. Social change involving Westernization need not mean concomitant political change because Mexico's political system takes credit for the social change that many Mexicans know is taking place.

Occupational stratification is changing as part of the movement toward a more industrialized society and away from an agrarian labor intensive situation. Table I-17 suggests occupational stratification changes from lower to middle class occupations between 1950-1970 (Wilkie,)

I-17

Statistical Abstract of Latin America, Vol. 21

Table 3602
OCCUPATIONAL STRATIFICATION IN MEXICO, 1950-70
(N and %)

Workers by Class and Subclass	Share of Workers ¹	1950		1960		1970	
		N	%	N	%	N	%
UPPER	**	134,087	1.6	231,834	2.0	564,231	4.4
Managerial	All	65,108	.8	95,132	.8	319,828	2.5
Professional	1/3	68,979	.8	136,702	1.2	244,403	1.9
MIDDLE/STABLE	**	546,088	6.6	961,421	8.5	1,299,817	10.0
Professional	2/3	137,960	1.7	273,405	2.4	488,806	3.8
Office workers	1/2	192,407	2.3	346,570	3.1	483,589	3.8
Tradesmen	1/3	215,721	2.6	341,446	3.0	322,422	2.4
MIDDLE/MARGINAL	**	823,176	10.0	1,324,911	11.7	1,728,938	13.4
Office workers	1/2	192,407	2.3	346,571	3.1	483,590	3.8
Tradesmen	1/3	215,722	2.6	341,446	3.0	322,422	2.4
Artisans ²	1/3	415,047	5.1	636,894	5.6	922,926	7.2
LOWER/TRANSITIONAL	**	1,653,292	20.0	2,370,898	20.9	3,208,686	24.8
Tradesmen	1/3	215,722	2.6	341,446	3.0	322,423	2.4
Artisans ²	2/3	830,094	10.1	1,273,788	11.2	1,845,854	14.4
Services	2/3	607,476	7.3	755,664	6.7	1,040,409	8.0
LOWER/POPULAR	**	5,115,450	61.8	6,442,952	56.9	6,148,385	47.4
Services	1/3	303,740	3.6	377,832	3.4	520,205	4.0
Agriculture	All	4,811,710	58.2	6,065,120	53.5	4,952,200	38.2
Unspecified	All	..	..	..	..	675,980	5.2
TOTAL	**	8,272,903	100.0	11,332,016	100.0	12,955,057	100.0

1. Estimates from Cline (1963b, p. 121).

2. Includes semi-skilled workers.

SOURCE: Calculated from Mexico, DGE (1951, p. 61; 1964, table 26; 1972, p. 229).

Source: Wilkie, James, "Quantifying the Class Structure of Mexico," ...

I-18

There seems to have been impressive social mobility in Mexico since 1895, with the middle class in a clear ascendancy and a declining percentage of lower class people. This fact is particularly important for health because "the lower class is subject to more disease, higher death rates (especially infant mortality), than the middle or upper classes. Illiteracy and poverty are closely allied conditions of the lower-class Mexican, whether in town or country, whether Indian, transitional, or 'modern.'" (Wilkie, 579)

What then are the figures on the class mobility. Wilkie has quantified the class structure of Mexico on the basis of occupational, income and other variables. The chart he developed (I-19) shows the impressive changes over a long period with the significant use of the middle class, and a significant percentage decline of the lower class (Wilkie, 585).

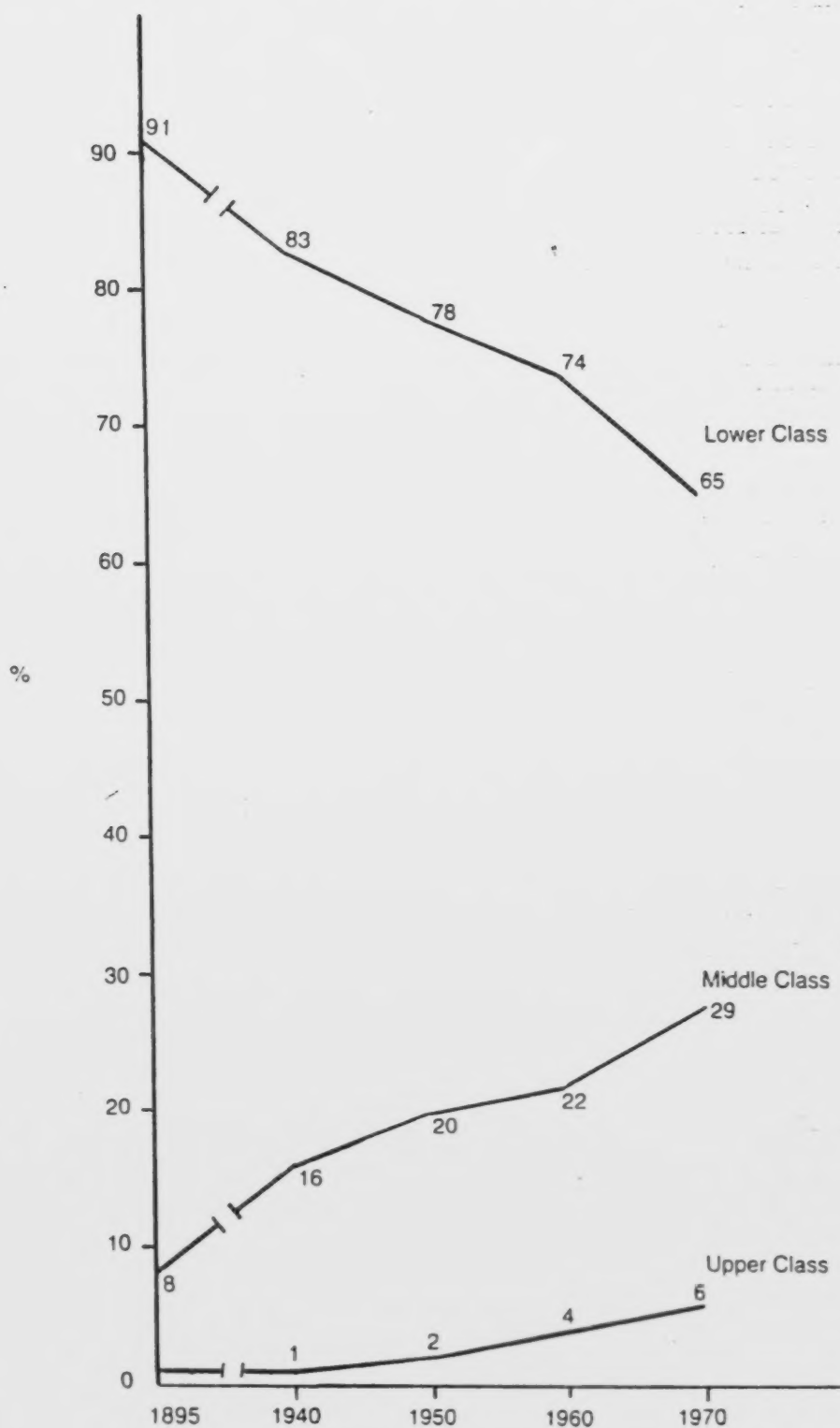


Figure 1. New series on the class structure of Mexico, 1895-1970.

SOURCE: Table 3605.

E. MEXICAN AGRICULTURE

1. Problems with Agricultural Populations

Mexican agriculture has been unable to deal with the growth and development needs of its population (Bizzaro, 370).

Despite the rapid urbanization of its population, the Mexican economy is still basically agricultural. But the economy bristles with paradoxes. A corn-growing nation, Mexico imports its tortillas. While 16,000 doctors are unemployed in greater Mexico City, more than 50 percent of the nation die without medical attention.

Food production has not kept pace with an annual population growth rate of 2.9 percent, which guarantees continued widespread hunger and wipes out more than half of the GNP increase. It is ironic that Mexico must export a great deal of the food it produces in order to pay for industrial products and maintain a reasonable balance of payments.

The rural poor are trapped; the arable land available for distribution has just about run out. Today, there are 3.5 million farm hands with a right to land, but there is no land to give them. Land scarcity has led peasants to invade unprecedented numbers of landholdings in the countryside, where violence has often erupted because of disputes between the peasantry and the land barons.

In addition, topographical features are not the best for crop increase (Alisky, 369).

Mountainous Mexico has few rolling plains, scant level farmland, and a climate ranging from deserts to swamps. Only 14 percent of Mexico's surface is cultivated for crops or grazed by livestock, despite a vast network of hydroelectric projects that add irrigated acreage to land without enough natural rainfall to support agriculture. The agricultural sector of the economy does not increase more than 2 percent a year, although the Banco de Mexico reported that in 1980 the gross national product grew 7.4 percent and was expected to do at least that well in 1981.

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The Mexican agricultural economy is tied to the economy of the United States and the world and is increasingly involved with production and export of products useful in the American market. This production includes tomatoes, strawberries, coffee and fruit, or the raising of cattle which offer a good return to landowners and a better balance of payments (Bizzaro, 371).

In contrast, production of the traditional grains and legumes that form the basic diet of most of the Mexican population has declined drastically. In 1981, Mexico produces only two-thirds of the grains it consumes; the rest is imported mostly from United States grain dealers. In the past five years, the acre yields of basic food crops were low: the acreage planted in corn in Mexico dropped at an annual average rate of 4.8 percent; production of wheat also declined while beans and sugar were in such short supply that most people could not afford them.

Market forces have been dominating the agricultural section since the late 1960's, and government policy was not formulated to counter market forces (Bailey, 357).

In consequence, (1) production levels of staples have remained rather stable over the past decade; (2) this meant a per capita decline in some areas of consumption; (3) given sharply unequal distribution, some groups in society are malnourished; (4) production for urban middle and upper income groups and for the export market has increased, leading to what critics call the "sorghumization" and "cattle-ization" of the countryside.

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These trends are not unique to Mexico and have appeared to one degree or another throughout the region. Distinctively Mexican is the mix of revolutionary tradition, geology and geography. One of the most powerful currents in the Mexican revolution is agrarian reform, and the symbols abound: Zapata, land and liberty, Plan de Ayala, and the ejido. Regime legitimacy, increasingly shaky since 1968, rests in part on sensitivity to issues of political justice in the countryside. This means that the calculus of efficiency in selecting policies must accommodate powerful political sentiments. Those who would address the agrarian question would do well to choose their terms and couch their arguments carefully, as John Gavin, the United States ambassador to Mexico, learned when he suffered the fallout from his criticisms of the ejido.

A dual agricultural system has developed in Mexico dealing with two different agricultural sectors (Walsh, 826)

One is comprised of commercial farms producing for an internal, urban market and for export; these farms are centered, primarily, in the irrigated lands in the Northwest, particularly in the states of Sinaloa and Sonora.

The other sector is dominated by subsistence farmers concentrating on growing basic foods, notably corn and beans. Peasant farmers operate in an almost infinite variety of conditions from semiarid to tropical. Many, for example, farm in mountainous terrain where soil erosion and early frost are chronic hazards.

A shortfall in basic food products is increasing and reflects problems for Mexican agricultural capability of meeting food needs (Walsh,).

The shortfall in corn underlines problems in Mexican agriculture that pose serious long-term difficulties for Mexican economic development. In basic terms, the demand for food created by rapid population growth is outpacing increases in agricultural production. This requires higher

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expenditures of scarce foreign exchange for food at a time when inflation, the leveling off of oil revenues, and devaluation of the peso are hampering the country's ability to service its heavy foreign debt and finance development.

The impoverished agricultural condition of Mexican farmers has resulted in undernourishment and has led to the development of ameliorative programs (Sheet, 375).

The program to increase domestic food production was designated by President Lopez Portillo in March, 1980, as the Sistema Alimentario Mexicano (SAM). In his announcement, the President described over 40 percent of the Mexican people as chronically undernourished. The program set targets to achieve self-sufficiency in corn and bean production by 1982 and in rice, wheat, soybeans and sorghum by 1985. SAM's aims are not only to raise the levels of food production and the efficiency of farmers, but to improve standards of nutrition and increase money incomes for small farmers who constitute the majority of agricultural producers in the country, even though most of them produce only enough food for their own subsistence.

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An index of per capita food production shown that food production was not under effective control by 1976 (Wilkie, 9).

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Table 112

INDEX OF PER CAPITA FOOD PRODUCTION, 20 L, 1953-76^a
(1961-1965 = 100)

Country	1953 ^b	1961 1965	1971	1976
A. ARGENTINA	98	100	98	116
B. BOLIVIA	66	100	110	124
C. BRAZIL	88	100	112	128
D. CHILE	102	100	105	92
E. COLOMBIA	105	100	107	106
F. COSTA RICA	123	100	134	140
G. CUBA	114	100	100	93
H. DOMINICAN REP.	108	100	104	98
I. ECUADOR	65	100	100	98
J. EL SALVADOR	~	100	105	110
K. GUATEMALA	97	100	112	123
L. HAITI	~	100	103	105
M. HONDURAS	102	100	117	107
N. MEXICO	78	100	110	104
O. NICARAGUA	~	100	115	109
P. PANAMA	90	100	123	113
Q. PARAGUAY	106	100	104	99
R. PERU	100	100	102	102
S. URUGUAY	124	100	88	106
T. VENEZUELA	82	100	120	124

a. Includes cereals, vegetables, starchy roots, sugar, pulses, edible oil crops, nuts, fruits, livestock and livestock products, cocoa, and wine.

b. Includes also coffee, tea, and linseed not counted here as food products beginning with FAO PY, 1976.

SOURCE: FAO PY, 1970 and 1977, pp. 31 and 77, respectively. Index base standardized for 1961-1965 = 100.

(Wilkie, Statistical Indicators, 9)

F. NEED FOR REFORM OF LAND TENURE PATTERNS

The principle of land reform as one of the key objectives in the Mexican Revolution (1911). A legal limit of 250 acres ownership currently prevails, although it is frequently evaded. Private farmers own about one-half of the arable land, with the other one-half under cooperative or communal ownership. About 40% of the non-private farm land is owned by the EJIDOS. These communal owned farms formed on expropriated lands, vary greatly in efficiency and prosperity. EJIDOTARIOS, can't sell or lease their specific parcels but must, if they wish to leave, return the land without compensation. This and other inflexible rules are blamed for impairing EJIDO efficiency and political corruption under rural bosses (Walsh, 826). But, the EJIDO system can't be blamed for the situation. It might well be viewed as an affect rather than cause of basic agricultural problems (Canabal Cristiana, 957).

Mexican agriculture has been in a state of crisis since the early 1960s, when agricultural policies of the Diaz Ordenez administration failed to predict relevant changes in the international market. The reformist actions of the following administration (Luis Echeverria), though well-intentioned, were unable to boost agricultural production. The government of Jose Lopez Portillo, in the process of trying to improve the situation, has sacrificed some of the rights gained by the peasantry during the 1930s in terms of land tenure & government opposition to large

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holdings. Hence, the peasantry, ill-organized & confused by contradictory claims, find itself defending ostensibly reactionary positions in order to retain its land rights. The tendency to see the peasantry as a traditional group fighting progress & modernization ignores the complexity of the situation; the social benefits supposedly to be gained by present attempts to capitalize Mexican agriculture should be examined more closely.

Agrarian populist groups campesinistas, have incorporated some marxist principles in attempting to bring about land reform. Gustavo Esteva, one of their leading proponents has noted that the peasant agricultural economy can coexist with capitalism over a long period. There is a populist faith in the value of the peasants. "The agrarian populists look to the peasantry in Mexico as a vehicle for Ru development, believing that a better understanding of the internal logic of peasant production might facilitate an alternative series of policy measures." (Redclift, 1373).

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II - THE POLITICAL ENVIRONMENT FOR HEALTH IN MEXICOA. POLITICAL NEEDS

The 1910 Mexican revolution serves as a symbolic point for Mexican nationalist focus (Bizzaro, 373)

Many Mexicans believe that the myth of the Mexican Revolution must be refurbished. For too long, Mexican workers and peasants have been deprived of an active part in national decisions. Awash with oil, Mexico has not found solutions to poverty, hunger, malnutrition, income inequalities or fragmentation along sectarian lines, nor has it been able to reorder its anachronistic social and political organization. And the ruling party (Partido Revolucionario Institucional), although it knows it can win elections, can no longer be sure that it can govern.

Today, there is one dominant political party in Mexico which consists of numerous groupings which might, in other nations, form splinter parties. This party is a major means of legitimation and social control by the regime (Leich, 361).

Until July 1, 1979, the Partido Revolucionario Institucional (Institutional Revolutionary party), or PRI, was all things to all men. Divided into three sectors - peasants, blue-collar and white collar workers - PRI still serves as a channel of political participation and mobilization and as a means of control over the social forces of Mexican society. Through the peasant umbrella organization and PRI component, the Confederacion Nacional Campesina, farmers in cooperatives and small landowners participate in political life through the filter of party control. Similarly, the Confederacion de Trabajadores Mexicanos, the labor component, is the umbrella organization for nearly all Mexican trade unions. The Confederacion Nacional de Organizaciones Populares, the white-collar component, attempts to provide a channel of participation for bureaucrats, clerks and civil servants.

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While the Mexican system institutionalizes a six-year presidential dictatorship, the constitutional body that legitimatizes this system is the Mexican Congress; and in particular the Chamber of Deputies.

The strength of the political system of Mexico is in its talent for controlling key domestic forces. The PRI, in power since 1929, "... dominates the labor and peasant movements and, through corruption, cooption or occasional repression has prevented the emergence of significant anti-Government factions. Other influential groups, including the private sector and leftist and rightist opposition parties, also function almost as appendages to the ruling political bureaucracy." (Riding, 4).

But the umbrella political organization as much as it can be described as positive for consensus development, can be described as negative for undermining the interests of labor groups (Novelo,)

An investigation of the history of the union of coal or zinc miners in Nueva Rosita, Coahuila, belies contemporary assertions of labor harmony in Mexican mining by showing the collusion of the national union, the mining companies, & the state in undermining worker demands... The national union, now controlled by conservatives, refused to support the local, & the government declared the strike illegal & sent troops.

B. THE POLITICAL ELITE AND THEIR CONNECTIONS

The elite groups of Mexico are the university educated elite. Education is evidently a means for upward mobility and changes in social class stratification (Camp, 967).

In spite of limited educational opportunities for the vast majority of Mexicans, those who have wielded national political power over the last fifty years have been extremely well-educated. Some 80% of them have held U degrees, primarily in law, with the majority from the U Nacional Autonoma de Mexico. Those leaders lacking advanced education have most often had success as Federal Deputies, union leaders, & functionaries of political parties. Surprisingly, in spite of the Ru origins of many military figures (particularly during the revolutionary 1920s), 50 + % of those who have pursued political careers have held U degrees. Those in the most prestigious & powerful positions in government tend to hold the highest degrees.

Support for Mexico's elite comes from their linkage with bankers in the Western World, the international group of bankers comes into contact with each other at international meetings and conventions (Astiz, 50).

The ties that have been developed between these individuals on the one hand and United States financial leaders and high public officials on the other hand cannot be ignored. They know each other; they understand each other's problems; they share the conceptual framework through which they perceive the world of the 1980's. If we include the regular exchanges of top personnel between the private sector and the United States government, we begin to understand that for many years political and economic relations between the United States and the Latin American countries have been based on the personal relationships between high-level Latin American officials and American bankers and bureaucrats.

C. INDEPENDENCE AND DEPENDENCY ON THE UNITED STATES

Mexico, until the oil glut, was able to back its political rhetoric as a regional power with a resource based foreign policy. In 1981, it was the fourth largest oil exporter in the World (Bagley, 353).

... oil is not the only factor involved in Mexico's recent rise to regional, power; in spite of severe and continuing economic problems, the Mexican economy has expanded and diversified considerably over the last two decades. During the 1960's, Mexico's annual growth rate averaged an impressive 7.0 percent, while in the slower growth years of the 1970's, it sustained a respectable 5.0 percent average. Mexico is no longer the backward and agrarian nation that it was a generation or two ago. It is, rather, a middle-income country with an economy of growing complexity and industrial capacity. During the 1960's, Mexican industry grew at the remarkable rate of more than 9.0 percent a year, while in the 1970's, it managed the more moderate but still respectable rate of 6.0 percent per annum. In 1978, industry contributed 37 percent of gross domestic product (GDP) (up from 29 percent in 1960), while the service sector accounted for 52 percent (down from 55 percent in 1960), and agriculture accounted for only 11 percent (down from 16 percent in 1960) (It was) ... a relatively sophisticated economy, well advanced along the path of industrialization (of a dependent and associated type, to be sure, but industrialization, nonetheless).

However, Mexico's independence has not lasted long. Mexico's continued dependency on the United States, and its failure to become an "actor" on the political scene despite its oil bonanza, a result from the fiscal consequences of the current oil glut. "Mexico's dependency ...

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has been intensified by its inability to pay the huge foreign debt it has acquired in the last few years, mostly because of the promise of those very oil reserves." (Astiz, 50)

Washington assumes that it has common security interests with Mexico and officials often describe Mexico as misguided in its unawareness of Cuban and Communist penetration of the hemisphere. But, the Mexican's perceive the situation quite differently (Bagley, 355).

... there is a relatively high degree of consensus among Mexican elites on several key elements. In terms of national security, there is a perception that the principal threat to Mexico is not Soviet-Cuban subversion, as the Reagan administration has claimed, but rather the United States itself. This perception is clearly rooted in Mexico's historic vulnerability to its dominant northern neighbor. In its contemporary version, the principal Mexican fear is that a severe disruption of world petroleum supplies might provoke a United States intervention in Mexico designed to guarantee United States access to petroleum during the crisis.

There are common interests shared between U.S. and Mexican elites.

"The United States is Mexico's principal trading partner, largest foreign investor and major international creditor, and thus shares with the Mexican elites a common vested interest in continued economic expansion in Mexico." (Bagley, 356)

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D. TENSIONS, PROBLEMS AND FEARS

Problems of Mexican society system make the society difficult to govern (Whitehead, 1376).

An interpretation of the Mexican political system is outlined which argues that the Mexican state is organized to bring about long-term changes in the society, without paying much regard to the immediate distribution of preferences among the existing population. The governing elite therefore feels a sense of remoteness from the society it seeks to transform, & suffers bouts of concern about the underlying "governability" of the country.

The Mexican state functions on two levels, on that of the modernizer and that of the fatherly-patrimonial state - the state as extended family (Paz,)

The state founded by the PRI party has grown strong while weakening the society in which it operates, creating parallel bureaucracies of politicians & administrators/technocrats. This state's two bureaucracies are run respectively on personal & technical patterns. Mexico has not undergone genuine modernization due partly to attempts to adopt patterns of modernity from other countries rather than developing them indigenously.

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There is a general feeling of apathy in Mexican politics resulting from the type of political discourse (Lopez, 111).

... although the different ideological apparatuses of the state reproduce the democratic phraseology of the revolution, they do not take into account the different realities of Mexican society. In this way, political discourse loses its effectiveness, as evidenced by the apathy of Mexicans in participating in politics & civic duties. Political discourse is not just rhetoric, but a combination of words & action.

Will the recently installed political power of de la Madrid be able to overcome the problems of governing Mexican society? (Mexico's Poverty, 43)

Many are pessimistic about their future and distrustful of de la Madrid. "Our Presidents all start by saying the right things and end as failures and thieves," says a worker. Another agrees: "All politicians steal, and de la Madrid won't be any better." They complain that the President has only made life more difficult for them. Mexicans have little faith in the President's anticorruption campaign and say that police demands for mordidas continue as before. An American businessman, based for years in Mexico City, claims he recently was stopped by a traffic policeman and had to surrender his wristwatch to gain his release. "The entire system is corrupt, and no one man can change it," laments a frustrated worker in the anti-corruption campaign.

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There is evidently a powder keg potential for upheaval in Mexican society. Most analysts however feel that the different interest groups have a common interest in keeping the umbrella political organization intact (Riding, 4).

By retaining the political initiative, the Government and its party have prevented any major opposition from taking shape. The labor movement, the most powerful political force in the country, seems willing to accept a drop in real wages in order to save jobs. Leftist parties fear that popular unrest would bring repression and are avoiding agitation. Rightist parties are linked to business interests which are looking to the Government for economic relief during the crisis.

Any threat to stability thus seems more likely to come through an explosion of discontent than through organized opposition. Apparently aware of the danger, the Government has avoided increases in public transportation fares or the price of corn tortillas, which could spark angry protests in urban slums. In this and other cases, the Government has concluded that high subsidies are a low price to pay for political tranquility.

While the de la Madrid administration remains determined to continue to dispense its bitter medicine, it is watching the body politic carefully for any dangerous side-effects. It is reluctant, however, to test the population's tolerance much further than it already has. Any signs of unrest or further drops in projected oil revenues would likely prompt it to turn abroad for more credit.

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F. PRESSURE FROM THE LEFT AND RIGHT1. The Mexican Left

The Mexican left also functions within the system and until now has focused on education as a means of political and social reform, rather than on upheaval (Imaz, 1277)

With the possibility of legal action, a large part of the Mexican Left has chosen to wage its struggle within the system. Its principal strategy is consciousness raising among the masses through the educational impact of the electoral process. The Mexican Communist party has led the way in accepting the political reform because of its belief that in the present state of ideological backwardness, the masses need to be educated first & thus prepared for the subsequent intensification of the SC struggle. Also discussed is the marginal Left, consisting of splinter groups that have rejected the reform for dogmatic reasons & continue to maintain a confrontational stance toward the state. The main goals of the Left are the political reorganization of the Wc & wider politicization of the popular sectors.

2. Danger of a Coup from the Right

The growing unrest in Mexico is unlikely to result in a leftist coup because the radicals have been socially tamed. What might result however is a more traditional Latin-American right wing coup (Mexico's Poverty, 42-43)

The key question in Mexican political circles is how long the people will endure the hardships of austerity before there is a widespread public backlash. Senior officials believe the government will endure, as long as it makes no major mistakes. Workers' talk of revolution is not taken seriously in high-level councils.

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Watching workers. In the street, however, it is clear that unrest is growing. Workers talk of being watched too carefully by the government, police and Army, and hint that if the right leader came along, revolution might follow. "We are a patient people," says a clerk in a Mexico City store, "but unless things improve, the time soon will come when there will be an uprising here. Many are convinced that then the Army will move in and kill us."

Political leaders consider the left to represent no real threat to the established order in Mexico, although they concede that could change rapidly in a time of serious stress. The assumption is that if there is an attack on the political system, it would come at the hands of the right or the military...

Mexico's military leaders seem anxious to stick to their traditional background role. Yet some experts believe they could move into action if rioting erupted beyond civilian control.

"I wish it were the month of December," says a de la Madrid adviser. "By the beginning of summer, it will dawn on our people that there can be no immediate relief for them. Then the worst months will come for us."

3. Attempts at Reform

The political elite evidently is attempting to cut back on consumption and visible corruption (Mexico's Poverty, 43)

Upon taking office, de la Madrid adopted a "shock treatment" policy of telling the Mexican people the truth about their economic troubles as a way of persuading them to cooperate.

The President ordered anticorruption measures, and a controller's office was set up to prevent public officials from enriching themselves in office. Cabinet ministers and their deputies now are prohibited from hiring relatives. Police have been reorganized in an attempt to stop the practice of demanding mordidas - bribes.

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De la Madrid, in contrast to the imperial style of his predecessors, is setting an example of modest behavior. At his order, for instance, his limousine now stops for red lights.

One of de la Madrid's cabinet ministers says: "I follow the President's example. When I go from my office to the National Palace, I walk instead of using my official car and driver. I travel on Mexican commercial airlines, not on official planes. And in restaurants, I order Mexican wines. The people are pleased with our rejection of ostentation."

III - HEALTH IN DEVELOPING NATIONS: A CONTEXT FOR MEXICAN HEALTH

A. CONCEPTUAL FRAME

1. Developmental Stages of Health System Development

Developed nations have passed through three stages of health system evolution. These are (Evans, 118)

The first stage dominated by major and minor infectious diseases linked to poverty, malnutrition, and poor personal hygiene, responded slowly to improved food supply, housing, and literacy made possible by greater prosperity, and to public-health measures, particularly safe water supply, sanitation, and immunization campaigns. The steady decline in infant mortality and the reduction in child mortality as a percentage of all deaths may be attributed to these changes.

... The second stage in the evolution has been dominated by chronic diseases, particularly cardiac and cerebrovascular diseases, cancer, diabetes, arthritis, and mental disorders. As the threat of infectious diseases receded, public-health measures were relegated to a regulatory role, and personal health services became the primary channel for prevention and treatment of health problems. The development of expensive and complicated technology for diagnosis and treatment has led to the transfer of care from doctors' offices to elaborate and expensive hospitals.

... A third stage of evolution reflects a shift from preoccupation with intrinsic disorders of structure and function of the body, to an awareness of the health hazards arising from environmental, exposure to an increasing number of chemicals, drugs, and other toxic substances and from changes in the social conditions of the family, community, and workplace that influence behavior and life style and are associated with absenteeism, violence, and alcohol and drug abuse of epidemic proportions. The meaning of the third stage as a return to the recognition that responsibility for health should not be exclusively the prerogative of the health professions - that protective and preventive measures have to be the responsibility of the individual and the society.

III-2

Industrialized countries have evolved through the three stages over the course of more than a century, industrializing nations don't have that time span. However, in developing nations there is more intensity because they often have to cope with all three developmental stages, simultaneously having to deal with (Evans, 119).

...the rural and peri-urban poor who constitute a majority of the population are in the first stage; the influential, more affluent urban dwellers are at the second stage; and manifestations of the third stage are already apparent because of environmental deterioration and the social disruption associated with massive urban growth and unemployment.

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2. Historical Diffusion of Western Models

Through conquest and cultural imperialism, Western medical models became the dominant form of medical organization in developing nations.

There were three major forms of this western colonial medical incursion.

The first form is (Gish, 205)

... the urban hospital, the rural dispensary - often Christian church related, and the hygiene or public health element. In essence, this remains the pattern in the Third World right up to the present.

The colonial hospital was built in the first place to meet the needs of colonial administrators and their families, and other Europeans residents in the colony.

The second form (Gish 205)

... The rural dispensary, like the hospital, was mainly a curative institution; primarily a place where drugs were dispensed to sick ambulatory patients. In certain respects it fulfilled the role played by pharmacies (and apothecaries) in Europe or North America at an earlier time - and sometimes still - where they diagnosed simple illnesses without charge and then sold remedies to match the diagnoses.

The third form of the colonial medical pattern was that of hygiene or public health (Gish, 205) and the urban hospital and plantation dispensary were developed. These forms enabled the establishment of a sanitary cordon to facilitate survival by Europeans in a hostile environment, and ensured the smooth flow of primary products from plantation to the ports of embarkation (Gish, 205).

III-4

3. The Flow of Human Capital in the Health Sector from Developing to Developed Countries

There is an outflow of health resources from developing nations. "Medical aid is mainly focused on teaching hospitals, perpetuating the pattern of production that benefits the consumption of the donor country and of those groups in the recipient country that Frank calls the lumpenbourgeoisie." (Navarro, 13).

The exodus of human health resources implies a very serious decapitalization for each donor country... the annual loss for the whole of Latin America due to the flow of physicians to the United States is \$200 million, a figure which is equal to Chile's education budget for 1970, or to the total medical aid given by the United States to Latin America throughout the decade of the 1960s.

The use of a technological base for medical services requires expenditures for services appropriate for a limited part of the population (Navarro, 13).

The pattern of production prevalent in the health sector of developing countries, as we will see later, is hospital-based, technologic and specialized medicine relevant to the needs of the lumpenbourgeoisie but not to the majority of the population.

B. CHARACTERISTICS OF RURAL UNDERDEVELOPED AREAS IN DEVELOPING NATIONS

There are a number of characteristics of rural developing nations of particular significance for health care (Djukanovic, 11-12).

- economic stagnation
- cultural patterns that are unfavourable to development
- agricultural underemployment, and lack of alternative employment opportunities
- poor quality of life because of the scarcity of essential goods, facilities, and money
- isolation caused by distance and poor communications
- an unfavourable environment predisposing to communicable diseases and malnutrition
- inadequate health facilities and lack of sanitation
- poor educational opportunities
- social injustice, including inequitable land tenure systems and a rigid hierarchy and class structure
- inadequate representation and influence in national decision-making.

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C. PROBLEMS OF HEALTH CARE1. Organization

There are number of problems which characterize health services in developing nations. One problem is the lack of clear national health policies and poor linkage of health service systems with other components of national development. Moreover, health should be considered as an integral part of development, with clearly defined goals, policies and plans. In many developing countries this approach is not followed. As a consequence, overall health goals and policies are missing, and this largely precludes health (Djukanovic, 14).

This poor linkage of services reflects a broader problem of deficiencies in management skills. These required skills are important for effective delivery of health services (Evan, 1121)

The health sector presents a formidable organizational challenge. Some of its objectives can be achieved only with the cooperation of other sectors such as water supply and sanitation, education, agriculture, and community development. The delivery of health services involves widely dispersed facilities, numerous categories of personnel, general and specialized hospitals, vertically organized programs to control individual diseases such as malaria, tuberculosis, leprosy, or venereal disease - each with its own personnel and support services, community health-care programs with multipurpose workers, and a system of indigenous medicine with traditional healers and birth attendants.

III-7

Also, there is a problem of the lack of clear priorities. Logical and realistic health priorities are rarely formulated (Djukanovic, 15).

... scant attention is given to the balance between curative, preventive, and promotional activities and the division of resources among them; curative services usually absorb a disproportionate share of money, manpower, and facilities. Priorities between primary care and referral care services are seldom defined in a general plan. Nor are priorities within the three main sectors themselves often clearly delineated. A balance is not always established on objective grounds between personal health services, environmental health services, and community-oriented activities. As a consequence, curative services and, more generally, personal services tend to receive undue emphasis, even when better results might be achieved by some other use of the same limited resources.

There is often inappropriate training of health personnel with the vested interests of the medical profession in conflict with the interests of broader health services. Training programs are (Djukanovic, 17):

... frequently irrelevant to or fall short of local health needs and aspirations: Examples of educational systems planned to provide suitable staff for national health needs are few and far between. Higher education... tends to create a communication gap between professional personnel and primary health workers, as well as between the professionals and unsophisticated people they should serve. Professionals are in the main unwilling to work in the rural areas where health services are most needed while, paradoxically, they resist the delegation to nonprofessional health workers of responsibility for primary health care.

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The medical profession often opposes new types of health personnel on the ground that providing medical care is too important, too complex, and too dangerous to be left in the hands of less trained or differently trained personnel. This opposition may be disruptive since, in order to function effectively, primary health workers need the active support of physicians or other health service staff.

The restricted use of primary health care workers is a problem particularly injurious to rural areas. There is an absence of thinking (Djukanovic, 20)

... about the kind of health personnel needed to provide the necessary services at the village level. Most preventive measures and a large number of medical procedures are simple and do not require extensive professional training. In recognition of this fact, there is now a trend towards establishing a body of primary health workers who can be trained more rapidly, less expensively and in greater numbers than doctors or nurses. It is particularly important to use them for primary care in rural areas.

An additional problem is that of physical and psychological access to health care to community needs, perceptions and ideologies. Community involvement and participation is needed to bridge this barrier between services and needs. Obstacles to community participation include (Djukanovic, 16):

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- in some countries a political system that does not encourage local self-government - a prerequisite to local involvement in health and development in general
- the rigid sectoral structure and centralized organization of most conventional government health services, (and)
- competition between the traditional system of health care already existing at the local level and the modern system of health care

2. Access

Uneven distribution of health services in favor of middle and upper income groups in urban over rural areas continues to pose a problem in developing nations (Evans, 1119)

Access to health services is very uneven, and large segments of the rural population are not reached. Health facilities and personnel are concentrated in urban areas, and within the urban population the services are oriented to the middle-income and upper-income groups, neglecting the peri-urban poor. Political considerations may override all other priorities, and little progress can be expected unless there is a political commitment to apply resources where the need is greatest.

Adequate and appropriate supplies for applicable levels of technology poses a problem for health service delivery (Evans, 1120)

The most widely used technologies in health are drugs and vaccines. Shortages of supplies and failure to provide for the timely distribution of drugs and vaccines are serious problems that must be overcome for an effective health program.

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Low income level, one of the characteristics of developing nations also is associated with poor health related indicators such as high birth rates, lower life expectancy infant mortality rates, access to safe water and food consumption (Evans, 1117).

Table 1. Health-Related Indicators in Countries with Different Income Levels.^a

INDICATOR	YEAR	LOW-INCOME COUNTRIES *	MIDDLE-INCOME COUNTRIES †	INDUSTRIALIZED COUNTRIES ‡
Gross national product per capita (\$)	1979	240	1420	9440
Crude birth rate (births/1000 population)	1979	42	34	15
Crude death rate (deaths/1000 population)	1979	16	10	10
Life expectancy at birth (yr)	1979	51	61	74
Infant mortality rate (deaths/1000 live births) §	1978	(49-237)	(12-157)	13
Child mortality rate (deaths/1000 children 1-4 yr old)	1979	18	10	1
Per cent of population with access to safe water	1975	25	58	¶
Daily per capita calorie supply (% of requirement)	1977	96	109	131
Adult literacy rate (%)	1976	43	72	99

*Thirty-four low-income developing countries with a per capita income of \$370 or less in 1979 (China and India are excluded from the low-income group in this table).

†Sixty middle-income developing countries with a per capita income of more than \$370 in 1979.

‡Eighteen industrial-market economies.

§Weighted averages; figures in parentheses denote the sample range.

¶Data not available but assumed to be close to 100 per cent.

||Requirements based on calories needed to sustain a person at normal levels of activity and health, taking into account age and sex distributions, average body weights, and environmental temperatures, as estimated by the United Nations Food and Agriculture Organization.

III-11

Also, there is inadequate health education particularly regarding childhood diseases, nutritional diseases and diseases preventable by immunization (Dukanovich, 22).

Deficiencies in communication and transport also are an essential cause of poor health service delivery to rural areas. Lack of basic sanitation also is a problem particularly as it relates to safe water, safe environment and uncontaminated foods, sanitary collection and disposal of human wastes, planning and control of urbanization, attention to proper housing and food hygiene (Dukanovich, 23). Rising health care costs related to inflationary and energy cost pressures aggravates the health problems of vulnerable community members by forcing individuals and government to prioritize use of limited resources.

III-12

3. Increased Number of Children with Health Needs in Urban Slums

A major problem in developing nations is the increased numbers of people moving from poverty in rural areas to poverty in slums and shanty towns of the magnet cities. Approximately 1/3 of the city dwellers in developing nations live in slums and shanty towns.

This poses significant health problems for children, who make up one-half of the slum and shanty town population and whose numbers are increasing dramatically. "This is the most tragic aspect of the problem - the slum conditions mortgage the future of many of these children, especially the very young in their most formative period of growth. Child mortality and suffering in these communities are very high and life expectancy is low."

(Djukanovic, 11)

III-13

4. The Prevalent Patterns of Consumption: Imbalance by Type of Care

The prevalent pattern of consumption are reflected in an imbalance in the type of health care provided (Navarro, 20).

... environmental health services and preventive personal health services should be given far higher priority than curative services, and particularly the hospital services. In spite of this, the production of human resources, through the medical education imported from developed societies, serves to perpetuate this hospital-oriented, curative medicine approach which only strengthens the maldistribution of resources according to type of care by replicating the consumption of health resources prevalent in developed societies.

... The orientation toward a hospital-based, curative medicine pattern of consumption seen in developed societies is replicated, through the medical education and the structure of health services, in underdeveloped countries, because the means of production and consumption in the health sector are controlled by the lumpenbourgeoisie, which desires the same type of care (with the "latest" in medical care) given to the people in developed lands.

... This pattern of consumption by type of care, in both developing and developed countries, is characterized by the broadening of choice for the few, and the narrowing of choice for the many. Actually, each dollar spent in Latin America on highly specialized hospital services costs a hundred lives. Had each dollar been spent on providing safe drinking water and in supplying food to the population, a hundred lives could have been saved.

III-14

Medical education in Latin America have Curricula, patterned on the German, French and American models. These (Navarro, 10).

... reflect an engineering approach to the understanding of the body and its diseases and tend to ignore the understanding of the socioeconomic environment that brought about the diseases. The emphasis on hospital-based, technologically-oriented medicine and especially individual, acute-episodic care, typical of the medical education of Western developed societies, is replicated in the developing societies. Rural, ambulatory, social, and continuous care is underrepresented, if not nonexistent, in the curricula of medical institutions in developing societies. When the rural type of medical care is taught, student exposure is apt to be more symbolic than real.

III-15

5. Expenditures for High Technology Rather than Public Health

The health care system is involved in costly expenditures on inappropriate technology (Navarro, 11).

... with the annual operating expenditures of the three open-heart surgery units in use today in Bogota, a city with a population of over 2 million, a quarter of the children living there could receive a half-liter of milk each day for one year. I should underline here that the main public health problems in the city of Bogota are not heart conditions but gastroenteritis, infectious diseases, and malnutrition. Furthermore, if indeed the experience of developed countries applies to developing ones, it is highly probable that, considering the high density of units for such a small catchment area, the care provided by these units is not really needed... there is too much, rather than too little, cultural and technologic diffusion from the developed to the developing countries.

This failure to provide appropriate health technology for the broader needs of populations also is noted by Djukanovic (Djukanovic, 15).

Much of modern health technology ... is inappropriate or irrelevant to the immediate needs of people in developing countries. Moreover, owing to the high cost of sophisticated equipment and other requirements, it tends to absorb, for the benefit of a minority of the population, a substantial share of limited resources that should be used to benefit all the people. This is a problem that needs to be dealt with by national governments.

III-16

6. Current Crisis in Developing Nations: Limited Access

A socio-economic crisis in the developing areas is very significant for the health problems being faced (Gish, 204).

This crisis is characterized by static or even worsening conditions for the mass of the population at the same time as a relative few appropriate the wealth of the nation to themselves. This process goes forward in the context of very rapidly growing and increasingly filthy urban environments, the general impoverishment of subsistence and other small peasants and farmers, unemployment and underemployment of unprecedented proportions coupled with the importation of inappropriate capital intensive technologies, rates of illiteracy that remain constant, together with growing university enrollments even in the face of graduate unemployment, and very rapid population growth flowing out of continuing poverty and inequality.

This socio-economic crisis is reflected in health care services being delivered and the types of (Gish, 204).

... services directed toward the wealthier members of the population, and which conform to the requirements of the most elite group of health care providers, the medical profession. Coverage of the population by even elementary health care services is often no greater than a quarter of the whole, and by effective and "caring" services it is even less.

III-17

7. A Situation of Wealth Controlling Health

Health Resources in Latin-America are used as a reinforcement of the social class structure (Navarro, 28).

The highly skewed distribution of human health resources in Latin America is a symptom of the maldistribution of resources in the different sectors of the economy, a maldistribution that, as postulated in this article, is due to the economic and cultural dependency of Latin American countries and to the control of the distribution of economic and social resources (including health resources) in those countries by a national lumpenbourgeoisie with foreign counterparts... it would be unhistorical to expect that changes towards equity can occur in the present distribution of resources, within and outside the health sector, without changing the economic and cultural dependency and the control by the defined social classes of the mechanisms of control and distribution of those resources.

Indeed, in Latin America today, it would be inaccurate to expect a more equitable distribution of human health resources within a highly inequitable distribution of all resources, because of the highly skewed distribution of the mechanisms of economic and political control... it would seem that the institutionalized political channels currently controlled by these groups are not adequate nor sufficient to stimulate the redistribution of resources in most of Latin America.

It is apparent that the institutionalization of the distribution of power and control in the mechanism of distribution of resources, inside as well as outside the health sector, is a profound, almost insurmountable, obstacle to the equitable distribution of human health resources.

8. Class Bias in Health Services

There is a clear class bias in health care planning and service delivery. (Gish, 206).

The leaders of the newly independent countries, and more particularly the medical leadership did not question the essential character of the health services they had inherited; instead, they aspired to spread these services to the whole of the population. The new services were to be "high standard," as defined by the medical elite, at the same time as they served the needs of the whole population. The very comprehensiveness of the plans almost always meant that only a fraction of them could be implemented, thus forcing (or allowing) the implementers to single out only particular projects for development. More often than not it was the prestigious hospital plan that was thus singled out, and not the health centers, rural clinics, or preventive programs. The rhetoric of the plans was - and still is - almost always at sharp variance with proposed expenditures. The rhetoric emphasized preventive and rural priorities at the same time that expenditures were overwhelming curative and urban.

The plans reflect not only the social and class views and interests of the medical doctors and their political superiors who develop them, but also the narrow initial clinical training of members of the medical profession. This is not to hold Third World doctors alone as responsible for the failure of most health planning as, obviously they are part of larger structures; but, health plans often have been even "worse" than they were politically "required" to be as a result of the almost total domination of health planning by medical doctors and the related exclusion of others. The abstract "health needs" approach to planning has clouded the need for explicit recognition of resource constraints to health development and consequent setting of specific priorities, including the almost certain downgrading of medically cherished projects such as "that new cardiac unit." To "plan is to choose" and yet the system of health planning in most countries either denies the need to choose or, in some few cases, makes the planning process appear to be so complex that nothing can flow from it in any reasonable time period.

III-19

The post-independence period, then, saw a continuation of the kind of health care systems in operation during the days of colonial rule. Of course, it was an expanded system that was coming to be staffed by nationals at all levels rather than by foreigners, as well as being more readily accessible to a somewhat larger proportion of the entire population. Nonetheless the system could not be characterized as being in any basic way, other than size, as different.

9. Maldistribution of Wealth Results in Maldistribution of Human Health Resources

According to Navarro there is a clear connection between wealth and health in Latin American developing nations. "... the main cause of the underdevelopment of health (is) the state of health or lack of it, of the political, social, and economic structures that determine the underdevelopment in the societies studied." (Navarro, 4). He claims that scholars have avoided this type of analysis and connection, and have dealt with health maldistribution in a vacuum, without considering its broader socio/political environment.

Navarro rejects the Rostow thesis that defines development as diffusion of entrepreneurial values and diffusion of capital. That the developed nations should transmit skill knowledge, technology and create a market economy for entrepreneurs in order to move the developing nations up to a higher level of development. (Navarro, 15)

The cause of underdevelopment and its consequence maldistribution of resources is not (a) the scarcity of the proper "values" and technology in poor countries, (b) the scarcity of capital, and (c) the insufficient diffusion of capital, values and technology from developed society to the underdeveloped country's enclave and from the enclave to the rural areas, but quite the opposite. The cause of underdevelopment in poor nations is precisely the existence of Rostow's "conditions for development" in these countries. That is, (a) too much cultural and technologic dependency, and (b) the underuse and poor use of existing capital by certain national and international groups who have control of those resources. Moreover, factors (a) and (b) determine factor (c), the "dual economies" with the advanced urban-based entrepreneurial market sector and the underdeveloped, rural-based, "non-market" marginal sector.

III-21

According to Navarro (Navarro, 15)

the main cause of underdevelopment is control of the economy by a small percentage of the population, Frank's lumpen-bourgeoisie, which has strong connections with international capital and close affinity to the values, tastes and forms of consumption typical in the developed countries... consumption patterns of the lumpenbourgeoisie and the middle class, stimulated by a "value system" aimed at producing a consumer society with Western, middle class standards of living divert capital from potential investment. It should be added that in Latin America the lumpenbourgeoisie and middle class make up only between 15 and 20 per cent of the population, and the majority of the people, who are not of lumpenbourgeoisie and middle class level, do not fully participate in the consumer society.

Rostow's argument on scarcity of capital usually is presented to support the view that (Navarro, 8).

that poor countries cannot afford to provide whole health care to the whole population" or also under the argument that poor countries can "only afford social security for a few sectors, and mainly the industrial urban based sector, because investment capital determines the overall important growth of the take-off stage." The concept of dual economies and societies is reflected in the existence of an unequal distribution of health resources between the cities and the rural hinterlands, with Western "hospital-based" medicine in the cities and the indigenous and "less developed" form of medicine in the rural areas.

IV-1

IV. HEALTH CARE IN MEXICOA. PROFILE OF HEALTH IN MEXICO

In 1972, the Ministers of Health of the Americas noted the importance of the health sector as a primary factor in economic and Social Development (Sixth Report..., 94). Between 1974-77 a number of programs were undertaken as part of the extension of health services. The infrastructure for extension of services included adding 384 health posts, 94 rural health centres, 15 urban health centres and 15 urban hospitals reorganization of the Department of Health and Welfare, and increasing health manpower. In addition, services manned by physicians and mobile units were planned for sparsely populated rural areas.

Health services to be delivered by the above infrastructure included Communicable disease control and epidemiological surveillance of infectious and paracitic diseases (e.g. Measles, Pertussis, Poliomyelitis, Veneral Disease, Rabies Control, Pinta, Leporsy and Orchocerciasis) as well epidemiological surveillance of yellow fever; accident prevention (the fourth most frequent cause of death); program for the detection of cervical and breast cancer; maternal and child health/family planning program, and Prevention and control of air, water and soil pollution (Sixth Report ..., 94-98) .

IV-2

1. Health Indicators

Health indicators for Mexico compared to Latin America and the U.S.A. in a 1975 publication indicate the following (Table IV-2)

(Gomez & Segovia, 239)

Population per physician is high, nurses per population is low, hospital beds per population are low but percentage urban population with water supply is reasonably high.

Table 9. Health resources of eight Latin American countries and the United States in recent years

Country	Population per physician	Nurses per 10,000 popula- tion	Hospital beds per 1,000 pop- ulation	Percent of urban population with water supply, house connections
	1968	1968*	1968 (approx- imately)	1969
Argentina	520	15.9	6.3	65.2
Brazil	2,800	4.5	2.2	30.2
Chile	1,800	20.6	4.0	56.7
Colombia	2,200	11.0	2.4	65.0
Cuba	1,130	14.9	4.8	76.5
Guatemala	4,550	7.4	2.3	39.7
Mexico	1,850	10.8	2.0	67.2
Peru	1,950	10.9	2.4	48.5
U.S.A.	658	88.1	8.3	—

* Graduates and auxiliaries

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Further health indicators, (Table IV-3-A), note that infant mortality, although high, was exceeded by some other Latin American nations, death percentage under 5 years was high and death percentage by communicable disease was high (Gomez and Segovia, 236)

In Table IV-3-B) the first cause of mortality in Mexico is noted as influenza and pneumonia, followed by diseases of early infancy and intestinal diseases.

A. Table 4. Selected health indicators of eight Latin American countries and the United States in recent years

Country	General mortality		Infant mortality	Death rates 1-4 years of age		Percentage of deaths under 5 years 1968 (approximately)	Percentage of total deaths by communicable parasitic diseases
	Crude death	Age adjusted death rates*		1968	1969		
Argentina	8.3	6.8 (1967)	60	2.6	15.8	3.3	
Brazil	—	—	—	—	—	—	—
Chile	9.0	8.7 (1968)	86	3.2	31.2	6.2	
Colombia	9.4	9.5 (1967)	78	11.7	46.7	10.7	
Cuba	6.6	5.6 (1965)	40	1.6	20.7	4.3	
Guatemala	16.6	15.7 (1966)	93	27.6	49.2	22.1	
Mexico	9.6	9.1 (1968)	64	99.8	43.9	8.4	
Peru	7.8	7.4 (1967)	75	9.0	46.4	14.6	
U.S.A.	9.4	5.0 (1967)	21.5	1.1	4.6	0.0	

* Standard population: estimate age distribution for Latin America

B. Table 5. First principal causes of mortality in selected Latin American countries and the United States in recent years*

Order of causes	United States	Argentina	Chile	Mexico	Guatemala
1	Diseases of the heart	Diseases of the heart	Influenza and pneumonia	Influenza and pneumonia	Influenza and pneumonia
2	Neoplasms, etc.	Neoplasms, etc.	Certain diseases of early infancy	Certain diseases of early infancy	Gastritis, enteritis
3	Vascular lesions affecting CNS	Vascular lesions affecting CNS	Neoplasms, etc.	Gastritis, enteritis, etc.	Certain diseases of early infancy
4	Accidents	Certain diseases of early infancy	Diseases of the heart	Accidents	Whooping cough
5	Influenza and pneumonia	Accidents	Accidents	Neoplasms, etc.	Measles

* Format from an idea in Project DISABO (Feld 1965) with some modifications and actualized information.

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IV-4

An interesting profile of health in Mexico is provided by the following recent Demographic Indicators Table . (Table IV-5), (Wilkie, 6).

Mexico's age structure has a concentration of population at the lower end of the age group affecting both its birth and death rates. Life expectancy at birth is improving and urban population is increasing. The health consequences of demographic and mobility features will be explored in a later section of this paper.

Table 104
DEMOGRAPHIC INDICATORS, 20 LR, 1960-80

Country		Total Population			AAGR 1970-76	Density (per km ²) 1975)	Birth Rate (PTI)		Death Rate (PTI)		Life Expectancy at Birth		Urban Population ¹		Growth Rates (%) 1960-79	Population by Age Group in 1975			65 and Over
		(T)					1965-70	1975-80	1965-70	1975-80	1965-70	1975-80	%			0-14	15-64	65 and Over	
		1970	1976	1980									1960	1979 ²					
A.	ARGENTINA	23,748	25,384	27,064	1.5	9.1	21.95	21.4	8.59	8.9	67.36	69.4	73.6	85.0	2.1	28.5	63.6	7.9	
B.	BOLIVIA	4,780	5,712	6,162	2.5	4.9	43.88	46.6	19.04	18.0	45.25	48.2	26.8	32.4	3.7	43.0	54.1	2.9	
C.	BRAZIL	95,204	110,123	126,389	2.8	12.8	38.01	35.3	9.51	8.0	59.68	63.6	46.1	63.1	4.5	42.0	54.8	3.2	
D.	CHILE	9,717	10,428	11,547	1.8	14.0	31.83	23.4	9.77	7.6	61.50	64.4	67.8	80.7	2.8	36.3	59.0	4.7	
E.	COLOMBIA	22,075	24,105	26,215	2.7	22.8	43.53	28.1	10.33	7.4	58.51	62.2	48.2	74.8	4.5	45.7	51.5	2.3	
F.	COSTA RICA	1,737	2,020	2,286	2.8	39.3	37.29	30.8	7.31	5.3	65.41	69.7	32.7	45.2	4.4	42.2	54.5	3.3	
G.	CUBA	8,585	9,528	10,626	2.09	83.2	31.14	28.9	6.37	3.9	71.01	72.3	40.3	46.2 ^b	1.3 ^b	38.0	55.6	6.4	
H.	DOMINICAN REP.	4,343	4,846	5,053	3.0	105.0	46.77	33.9	12.33	5.2	55.68	57.3	30.1	52.0	6.0	48.0	49.4	2.6	
I.	ECUADOR	6,011	6,873	8,303	2.1	25.1	44.62	43.2	10.99	10.7	57.18	60.8	34.9	43.0	4.2	46.0	51.2	2.3	
J.	EL SALVADOR	2,516	4,224	4,813	3.5	192.0	44.23	41.7	13.00	7.8	54.87	62.2	38.4	40.2	3.5	46.5	50.3	3.2	
K.	GUATEMALA	5,298	6,010	7,100	2.8	56.3	44.64	41.4	15.69	12.7	50.12	57.8	33.6	29.4	2.1	44.2	53.0	2.3	
L.	HAITI	5,201	4,668	6,665	1.7	211.8	44.56	26.8	19.72	14.5	44.46	52.2	15.9	24.0	3.9	42.9	54.1	3.0	
M.	HONDURAS	2,553	2,769	3,595	2.7	27.2	51.11	41.5	17.54	5.7	49.38	53.1	22.8	35.1	5.7	46.9	50.3	2.3	
N.	MEXICO	50,313	62,329	69,965	3.5	30.0	42.80	41.7	9.73	7.6	60.98	65.6	50.7	64.2	5.0	45.9	50.6	2.5	
O.	NICARAGUA	1,970	2,218	2,733	2.9	17.9	48.56	41.2	15.65	5.4	50.43	52.9	38.4	56.6	5.1	48.4	49.2	2.4	
P.	PANAMA	1,458	1,719	1,927	3.1	22.2	38.33	29.5	3.08	4.8	64.90	67.9	41.5	53.1	4.4	42.8	53.4	3.3	
Q.	PARAGUAY	2,247	2,739	3,085	3.5	6.4	43.67	39.5	10.10	8.1	59.41	63.6	35.4	38.4	3.1	47.3	50.0	2.7	
R.	PERU	13,248	16,094	17,711	3.0	11.8	42.98	39.4	13.69	11.6	53.38	57.2	46.2	69.1	5.1	44.1	53.0	2.9	
S.	URUGUAY	2,887	2,782	3,244	7	16.4	21.21	20.5	9.36	10.1	69.28	69.0	80.8	81.3	8	27.9	63.1	9.0	
T.	VENEZUELA	10,559	12,367	14,134	3.1	13.4	39.55	36.5	7.94	6.0	63.00	65.8	66.7	77.1	4.1	44.4	52.5	3.1	
LATIN AMERICA ²		275,470	311,636	363,617	2.8	15.8	38.51	37.2	10.28	9.3	59.51	61.4	49.4	64.1	4.2	42.2	54.1	3.7	

1. Urban: over 20,000 inhabitants. a. 1977
2. Includes Barbados, Guyana, Jamaica, Trinidad and Tobago. b. 1960-1977

SOURCE: ECLA-S, 1973, pp. 639 and 675. SPTF, 1977 and 1979

Table 105
AGE STRUCTURE, 20 LC, 1960 AND 1970
(%)

Country	0-14 Years		15-64 Years		65 Years and Over	
	1960	1970	1960	1970	1960	1970
A. ARGENTINA	31.0	29.0	63.0	63.0	6.0	8.0
B. BOLIVIA	42.0	42.0	54.0	55.0	4.0	3.0
C. BRAZIL	42.7	42.0	54.4	55.0	2.9	3.0
D. CHILE	40.0	39.0	56.0	55.0	4.0	6.0
E. COLOMBIA	47.0	47.0	50.0	50.0	3.0	3.0
F. COSTA RICA	48.0	44.0	49.0	52.0	3.0	4.0
G. CUBA	-	-	-	-	-	-
H. DOMINICAN REP.	47.0	48.0	50.0	49.0	3.0	3.0
I. ECUADOR	45.0	47.0	52.0	50.0	3.0	3.0
J. EL SALVADOR	45.0	47.0	52.0	50.0	3.0	3.0
K. GUATEMALA	45.0	46.0	52.0	51.0	3.0	3.0
L. HAITI	42.0	42.0	55.0	53.0	3.0	5.0
M. HONDURAS	48.0	47.0	50.0	51.0	2.0	2.0
N. MEXICO	44.0	46.0	52.0	50.0	4.0	4.0
O. NICARAGUA	47.0	47.0	50.0	50.0	3.0	3.0
P. PANAMA	43.0	43.0	53.0	53.0	4.0	4.0
Q. PARAGUAY	45.0	46.0	51.0	51.0	4.0	3.0
R. PERU	44.0	45.0	52.0	52.0	4.0	3.0
S. URUGUAY	28.0	28.0	64.0	63.0	8.0	9.0
T. VENEZUELA	46.0	47.0	51.0	50.5	3.0	2.5
UNITED STATES	31.1	28.5	59.7	61.6	9.2	9.9

SOURCE: Adapted from WB WT/6, Series IV, table 2 and table 628, here

Wilkie, Statistical Abstract, 6

IV-6

B. ORGANIZATION

The Mexican health system is fragmented into three separate service areas. The Public Health Services (SSA), based on a Public Health model the Occupational Health Services (IMSS) based on a social security plan, and private health services. These different approaches developed within a historical and industrial context and currently exist side by side. This tri-partite model is characteristic of developing nations and requires an integrated regional approach to be overcome. I have developed the following tables from the Lopez-Acuna article to illustrate the differences between the three types of services, organizational base and constraints.

HEALTH SERVICE CATEGORIES (Jerez-Azua)
INSTITUTIONS DELIVERY SERVICE

CONSTRAINTS

THREE BASIC TYPES OF SERVICE

1. PUBLIC HEALTH SERVICE

Health services based on the right to health care of the entire population; and on state's responsibility to provide services for the promotion, preservation and recovery of health

1. "This includes the medical care services of the Secretaria de Salubridad y Asistencia (SSA), the Departamento del Distrito Federal (DDF) or Regency of the Federal District, the Sistema Nacional para el Desarrollo Integral de la Familia (DIF), and the so-called "decentralized" hospitals and institutes, under the auspices of a mixed public and private patronage generally headed by the SSA, such as the National Institute of Cardiology, the National Institute of Nutritional Disorders, and the Children's Hospital of Mexico."

1. "The SSA, with a relatively meager budget, has to deal with the basic activities of nonpersonal health services: surveillance, eradication and control of selected diseases, environmental sanitation, control of pollution, nutritional programs, etc., as well as the responsibility for providing medical care to two-thirds of the population. There is also a Bureau of Occupational Medicine that belongs to the Secretaria del Trabajo y Prevision Social (Department of Labor) and is concerned with occupational health problems and regulations. Another Bureau of Occupational Medicine exists in the Instituto Mexicano del Seguro Social (IMSS), with some duplication occurring as a result. A Bureau of School Hygiene operates within the Secretaria de Educacion Publica (Department of Public Education), and not only supplies health education materials to the elementary schools but also provides ambulatory medical care. And, lastly, the Secretaria de Comunicaciones y Transportes (Department of Transportation) has a Bureau of Preventive Medicine that is in charge of the medical inspection of the drivers of public transportation.

2. OCCUPATIONAL HEALTH SERVICES

Medical care services of selected government agencies of the social security institutions and selected government agencies.

2. This includes the Instituto Mexicano del Seguro Social (IMSS); Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE); Petroleos Mexicanos (PEMEX), (the national organization that administers the oil industry); Comision Federal de Electricidad (CFE), (the Federal Commission for Electric Energy); Ferrocarriles Nacionales (FNM), (the national railroad agency); Secretaria de Hacienda y Credito Publico (SHCP), (the Mexican Department of the Treasury); Secretaria de Marina (SMN) (the Mexican Navy); and the Instituto de Seguridad Social de las Fuerzas Armadas Mexicanas (ISSFAM), (the Mexican Institute of Social Security for the Armed Forces)." ... It is based on a guild right to delivery of medical care services, through different financial schemes, either bilateral or trilateral (employees, employer, and/or State contributions)

2. "The social security institutions, with more adequate budgets for health services, do not include nonpersonal services; they provide only curative medical care, rehabilitation, and, in a few cases, preventive care."

THREE BASIC TYPES OF SERVICE

3. PRIVATE HEALTH SERVICES

Private health services that provide medical care to individuals chiefly on a basis of direct purchase of the services.

INSTITUTIONS DELIVERY SERVICE

3. "Private health insurance is very scarce, limited to some white-collar banking workers or to upper- and upper-middle-class individuals. Most of the private health services are provided through solo practitioners and hospitals that sell their services in a free market at very high prices."

CONSTRAINTS

3.

IV-9

The Public Health Service (SSA) had developed components to service both urban and rural areas. The "A," "B," and "C" level services are an attempt to target government health services on the basis of demographic realities (Vivientsu, 145)

Mexican government health services are offered by the Secretaria de Salubridad y Asistencia (SSA, Ministry of Health and Welfare) and are organized into a regional hierarchy at the state-government level, a model not uncommon in other parts of the world. The SSA system is paralleled by several social security programs first established in the 1940s to cover certain employee groups. Until recently rural health care was exclusively the responsibility of the SSA, but in 1973 the largest insurance group, the Instituto Mexicano de Seguro Social (IMSS, Mexican Institute of Social Security), began to deliver such services to limited groups of farmworkers. The independent development of these insurance systems has created some duplication of services, but the government's 1974 10-year plan for health care called for greater integration of all the programs into a national system.

In accordance with the national model, the SSA maintains a major hospital and in many cases a medical school or other training center for health personnel in the principal city of each of Mexico's 32 states, and one or more large (A-level) outpatient clinics in the principal and other important cities. In other large towns in the state, B-level health centers, with a few inpatient beds and a staff of doctors, licensed nurses, and auxiliary nurses, are maintained. C-level health posts, the focus of the present study, are located in some of the smaller towns and villages and are generally staffed by a pasante (a newly graduated physician doing the required year of government service) and by an auxiliary nurse.

IV-10

Occupational Health Services (IMSS), are targeted to favored industrial groups in urban areas and works in the following manner. ("Progress in the Delivery of Health Care in Mexico," JAMA, April 18, 1980)

A social security system, embodying health and welfare services and retirement benefits, became law in Mexico in 1943. In addition to supporting community welfare services, it has struggled to develop a format and resources for delivery of health care to the masses of Mexicans, including the poor or those too isolated from urban centers to have any effective access to the benefits of modern health technology.

... the family physician is located in the family medical center, which itself is carefully located, constructed, and staffed to provide a neighborhood or community facility close to the people it serves.

... The family medical center has a patient distribution of approximately 50% adults and 50% children. The standard urban unit is staffed by about 20 physicians (who work half-time), ten nurses aides, two social workers, one dentist, one epidemiologist, a family planning specialist, and laboratory technicians.

All patients must be seen first by the family's personal physician who refers special problems to the hospital, which is staffed by all the major specialists. Only emergencies go directly to the zone hospital. Here, all care at the secondary level is provided, again within limits as set by the system. Only the most complicated problems requiring sophisticated diagnostic and treatment modalities or subspecialist care are referred on to the tertiary care center.

IV-11

In practice and by design, about 85% of problems are handled at the community level, 10% to 12% at the zone hospital, and 2% to 3% at the tertiary care medical center.

Services in this system are available only to the employed and his immediate family; they continue after retirement. Financing of care is by contributions from each worker, his employer, and the government. For those unemployed or self-employed, the government provides services in a separate system of care. In rural areas the community is permitted to work out "in kind" contributions. The system now covers about 50% of the population and is expected to be extended to and encompass most of the remainder as facilities are built in the next two years. Only a small percentage of the population seeks private care or is covered by other insurance systems (e.g. armed forces, railroad workers, and government employees).

Each region works out its budget, based on funding calculated from the number of physicians and types of services provided, including consideration of special health needs or delivery problems of the region.

IV-12

There is an imbalance of facilities appropriate for a developing nation and the types of services provided do not adequately Mexican health care needs (Lopez-Acuna, 91)

The institutions that provide health care in Mexico devote very few efforts and resources to the nonpersonal and preventive services and concentrate their activities on medical care with a dominantly curative approach. The hegemonic model of health care is a hospital-based approach to cure, care, and rehabilitation, a system which is very expensive and highly dominated by the influence of the drug and medical supplies industries. Ambulatory care and the organization of general practice are poorly developed. Screening, health promotion, sanitation, environmental control, occupational health regulations, prenatal care, health education, vaccination programs, and other preventive and nonpersonal services receive very little emphasis and very few funds.

The composition of Mexican health facilities also is inappropriate for a developing nation (Lopez-Acuna, 91)

"The composition of the health facilities is also inappropriate. The figures of 1970 show that there were 1566 general hospitals, 343 specialized hospitals, 1497 health centers, 526 clinics, and 582 health posts. In other words, the number of primary health care facilities and the number of secondary-and tertiary-level units were not balanced proportionally. The predominance of hospitals has constrained the development of primary health care units as the basic network of the Mexican health care system."

IV-13

To provide universal health service coverage, Mexico has begun a major national program to expand health services (Meneses, 248).

The program envisages extension of health services to rural and deprived urban dwellers; more efficient use of existing medical and sanitary services; increased community participation; strengthening of preventive health, health promotion, and sanitation measures; and, above all, the strengthening of family planning services. Achievements to date include creation of teams of health personnel instructors at the national, regional, and local levels; preparation of 57 nurse-instructors, 104 community-oriented family physicians, 2,300 rural health auxiliaries, and 983 rural sanitation auxiliaries. Most of these personnel began their new work in early 1978, thereby inaugurating the first real operational phase of this campaign to provide health services for all."

IV-14

C. POVERTY AND POOR HEALTH CONDITIONS IN RURAL AREAS

Mexican urban health conditions are made worse by the influx of rural people and the consequent expansion of urban need. (Meneses, 247)

Mexico is currently confronted with the fact that 13 million people, the vast majority from rural areas, have settled in underserved outlying areas of large cities under conditions of extreme social poverty. That there is a "combination of unemployment and underemployment, low educational levels, unhealthy housing, poor sanitation, malnutrition, deteriorating health conditions, social apathy, and above all a consequent lack of will and initiative to contribute to improving the situation". (World Health Organization. Report of the Director General, Document A/29/29. Geneva, 12 April 1979)

To help these conglomerations of people, the Ministry of Health and Welfare is promoting decentralization of material and human resources in the urban type "A" health centers and general hospitals. This decentralization is directed at creating primary health care units capable of achieving better utilization of resources at the neighborhood level.

IV-15

Mexico has a program to extend health care to rural and urban areas.

President Jose Lopez Portillio initiated health sector changes in Dec. 1926.

The policy aims of these changes were (Meneses, 244)

- 1) To extend health service coverage to the rural population and the underprivileged groups in large cities.
- 2) To take maximum advantage of the installed capacity of medical and health services.
- 3) To promote community participation in health programs.
- 4) To strengthen preventive health activities, health promotion efforts, and measures directed at environmental improvement.
- 5) Above all, to strengthen family planning programs.

There are three types of health centers in Mexico developed by the Ministry of Health and Welfare to facilitate achievement of the above aims.

These are types "A", "B", and C (Meneses, 245):

Type "A" health centers are located in cities of 20,000 or more inhabitants; their principal functions are promotion of health, and preventive medicine. They do not have hospital beds, and personnel is related to the programs they develop.

Type "B" health centers are rural hospitals located in communities of 5,000-15,000 inhabitants. They have a health team and provide general medicine and surgery, training, supervision, and evaluation.

Type "C" health centers are located in communities of 1,000-3,000 inhabitants. They are the minimal unit in the formal system, having two medical/social services and two auxiliary nursing personnel, a vehicle, and sometimes temporary hospital beds.

IV-16

Basic strategies to achieve the above policy aims and the means for implementing these strategies are (Meneses, 245-6):

<u>BASIC STRATEGY</u>	<u>IMPLEMENTATION</u>
"To build up a multidisciplinary team of teachers providing health instruction at the national, regional, and local levels."	"Multi-disciplinary teams planned and implemented the training of "... the health auxiliary providing primary care services in the areas of preventive medicine and family planning; the auxiliary trained in basic sanitation working to improve the rural environment; the empirical midwife retrained to provide improved care during normal childbirth and in matters of family planning; and the socio-economic promoters assigned to act as a catalyst promoting community development."
"To seek community participation by training elected local residents, with the aim of incorporating them into health programs."	"... emphasis was placed on having individual communities construct the facilities needed at the local level by the auxiliary team responsible for implementing the primary care program. At present 2,300 facilities of this kind are available."
"To reactivate or expand health units at municipal centers constituting principal foci of social, political, economic, and cultural development for the rural population."	"... rural clinics and type "C" health centers providing the second level of health care are being relocated, remodelled, constructed, or reorganized in accord with programs entrusted to teams consisting of two physicians engaged in social service and two

IV-17

BASIC STRATEGYIMPLEMENTATION

auxiliary nurses. These teams are responsible for surveillance of health conditions in a given number of localities within their established geographic areas of jurisdiction, and they possess the means of transport needed to accomplish this task. Of the 1,500 second-level medical units planned as a medium-range goal, 250 were in operation as of January 1978, and over 400 as of June 1979."

"To reactivate, expand, and construct type "B" health centers for the purpose of developing them into regional rural hospitals capable of supporting the rural clinics and type "C" health centers existing in their respective zones of influence.

"And finally, to promote the fourth strategy (strengthening of type "B" health centers), 47 type "B" centers are being constructed remodelled, or re-equipped as rural hospitals in order to support community services within their jurisdiction in matters relating to health care assistance, social organization, and personnel training."

IV-18

As with most developing nations, rural health delivery services are less adequate than those available to urban areas (Lopez-Acuna, 91)

Differences between the urban and rural areas are marked. The census of 1970 revealed that there were 97,653 localities in the whole country, but only 2600 communities have professional medical services available at the present time. Although the Secretaria de Salubridad (SSA) maintains about 1600 health centers in the rural areas, more than 90,000 localities are uncovered.

In 1976 Mexico had one of the lowest ratios of beds per 1000 inhabitants among all the American countries: 1.2. For the same year Cuba had 4, the United States 6.4, and Canada 9.2 (15). The scarcity was again aggravated by the concentration of beds in the urban areas and the social security institutions.

Professional care is less likely to be available in rural than in urban areas. 80% of the doctors are concentrated in the big cities and localities of more than 50,000 inhabitants. There are 1121 municipes (the equivalent of counties), with a population of more than 5 million people, which have no physicians. There is a national ratio of one physician per 1063 inhabitants, but this is not true for half of the population, for whom the ratio is one per 6500. A similar phenomenon occurs with dentists: 95% of the 18,000 who are licensed to practice do so in the metropolitan area of Mexico City. In some states of the country, such as Tlaxcala, there is a ratio of one dentist for 52,000 inhabitants (Lopez-Acuna, 90).

IV-19

D. HEALTH BEHAVIOR1. Dual Phenomena

In Mexican rural areas, one finds two health behavior phenomena. The movement to replace traditional indigenous medical systems through modern scientific medicine, and the continuation of indigenous elements in the indigenous health systems which are undergoing changes toward modernization.

In his studies of a mestizo Mexican community in Jalisco, McLain noted (McLain, 341) that traditional persons have greater flexibility to live in both types of health world and that behavioral change generally came before rather than after perceptual change of appropriate health care responses. Living in two worlds is made much easier through compartmentalization of traditional and modern scientific medicine (McLain, 341).

"... it was found that in a rural community undergoing modernization, traditional persons are more flexible health actors than are modern-oriented persons. Specifically, they tend to participate fully as health actors in both the traditional and the modern medical systems. On the other hand, more modern-oriented persons tend to restrict their participation to the modern medical system. Traditional persons, being heterogeneous in medical belief and practice, thus emerge as more adaptive in a context of medical diversity. Second, distinctions were found between perceptual and behavioral change influenced by the modern medical system. Specifically, behavioral change proceeded at a faster pace. Possible explanations of the difference include (1) the

IV-20

hypothesis that culture core traits resist change and that medical perceptions are culture core traits, and (2) that medical practice changes more rapidly because of the obvious technological superiority of modern medicine. It is suggested here that an equally compelling hypothesis is that models of modern medical practice are available to lay persons and to traditional medical specialists, and so elements of modern medical practice are incorporated into the traditional system where they are compatible. However, models of modern medical perceptions and theory are hidden from traditional specialists and lay persons primarily by modern physicians who typically do not discuss diagnostic and etiological considerations with their clients. Thus, traditional etiology persists in combination with more heterogeneous medical behavior.

The conflict between traditional medical personnel and scientific medicine is reflected in the function of traditional midwives in the health system.

Utilization of traditional midwives in rural experimental programs suggests the value of a reapproachment between the systems (Elu de Lenero,

65)

It has long been argued that traditional medical personnel, particularly Ru midwives, should be incorporated into the institutional health system in Mexico. Until 1973, they were ignored, if not actually persecuted, by health authorities. In 1977 a Ru health program was started seeking cooperation with them; by 1980 it was functioning in 11,500 communities of the existing 13,800 with 2,500 + inhabitants.

IV-21

Each of the two worlds of medicine, traditional and scientific, is viewed as appropriate for different categories of illness. This makes it possible for a person to live in and utilize both worlds on the basis of the defined disease. The following is a list of traditional and modern diseases in Ajijic, a rural Mestizo community in Jalisco. (McLain, 343)

Table 3. Traditional and modern diseases common in Ajijic

TRADITIONAL DISEASES	
caída de la mollera (fallen fontanelle)	tristeza (sadness)
ético (a digestive disorder)	morcizuelo (seizures of infants)
empacho (also a digestive disorder)	ojo (evil eye)
la bilis (bile)	hechiceria (witchcraft)
susto (fright)	
MODERN DISEASES	
anemia	bronchitis
hepatitis	enteritis
amebic dysentery	colitis
diabetes	pneumonia
infectious diarrhea	

The above list of hot and cold foods is a traditional list but not definitive. Foster has found that the "hot" and "cold" items in traditional Mexican medicine vary dependent on the time passage of an informant. (In a sense this suggests that traditional medicine is more of an art, and the Curandero an artist sensitized to client needs, rather than a science and a body of transmitted definitive knowledge. Foster found a 20% variation in the key informants definition of hot and cold foods 4 years after (Foster,)

IV-22

Traditional anthropological research designs, hypotheses, and models assume a high degree of cognitive and behavioral homogeneity within any culture of community. Contemporary research shows that such homogeneity is deceptive... In the Mexican Spanish-speaking peasant village of Tzintzuntzan, a 184-word list of foods & herbs was submitted to 10 informants. The same list was submitted to the 3 most knowledgeable informants in the sample 4 years later; the second set of replies deviated about 20% from the first.

IV-23

2. Marginality: Caused by Internal Backwardness or Result of External Institutional Denial of Opportunity

Young studied Pichataro, a community of three thousand residents to learn more about medical choice in a Mexican village. The village based on a subsistence agriculture of maize was primarily Indian with Tarascan as the major language. There was a generalized folk-catholicism as a common religion, and a degree of poverty as a common economic experience.

Decisions on how to treat illness were related to the environment of poverty both of Pichataro and of the broader Mexican community. A relationship of marginality from the urban community was shared by Pichataro with the general rural indigenous sector (Young, 39). There was an absence of an effective participation in the broader national society and economy.

There are two different explanations for this marginality and logical developmental designs that flow from each. Does marginality result from internal community factors such as peasant conservatism, resistance to change and fatalistic world views. Are these the causes of backwardness? If so, the way to overcome this internal cultural impediment to change is through education such as cultural missions, and reorienting local identity to a national and more modern context.

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Or does marginality result from a peripheral position of the community in relation to urban wealth and the economic elite in society? Are political factors to blame for the exclusion of the community from the national economy? True there is integration with the cash economy through wage labor migration, but there also is dependence and a failure to share in the benefits of petro-development. This second view would hold that control over local resources has passed from this local community to the wealthier urban sector of the nation. Poverty in this view would be a result of a national economy and development. This would mean that backwardness is a result of institutionalized denial of opportunities to participate in the national economy.

What are the health implications of each of these two views?

(Young, 42)

... the contrast between explanations of marginality that point to internal "cultural peculiarities" of peasant communities, and those that cite features of inequality and exclusion in the relations of such communities with the larger society, is analogous to a current debate concerning the reactions of rural people to modern medicine. Is the low utilization of modern medicine by rural Third World peoples primarily due to the influence of so-called cultural factors, such as traditional beliefs and values, or is it due to factors of inaccessibility and exclusion?

There is a frequently encountered assumption concerning use of medical services by rural people in developing nations. That the degree of congruency between folk-beliefs and modern medicine is the key factor in whether or the folk people will use the service. This, in a sense, blames the victim. Young has pointed out in his study on Pichataro in Mexico, the key variable is access to services, not congruency with folk-beliefs and ideology (Young, 1453-1463).

We conclude that accessibility, rather than the degree of conceptual consistency between local ethnomedical theory and Western biomedical theory, is the principal factor facilitating or constraining decisions to seek a physician's treatment in this setting.

... What we do assert is that when access to Western health care is as problematic as it is for the people of Pichataro- and Pichataro certainly presents no extreme case in this regard - to suggest that traditional beliefs represent a primary constraint on the choice of such care is to misplace responsibility for low utilization rates. When beliefs are held constant and accessibility is increased ... substantially. The results of this study thus fall in line with those existing studies that have stressed accessibility factors in explaining the reaction of rural Third World peoples to Western health care, and argue against a strict conceptual-compatibility model of physician choice.

IV-26

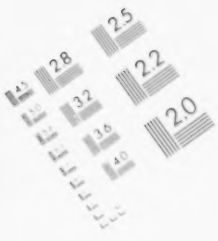
Health Decisions as Broad Cultural Expressions

The process of decision-making on whether or not to use modern scientific methods of contraception is not exclusively a question of use or non-use of modern scientific health methods. The traditional methods of birth control are culturally integrated into basic/core value systems which come into question when new methods are proposed. As noted by Shildin, (Shildin,)

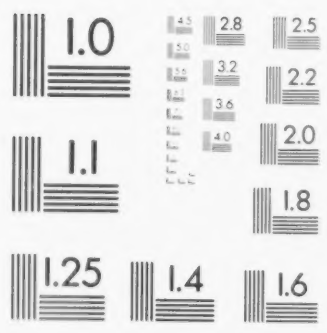
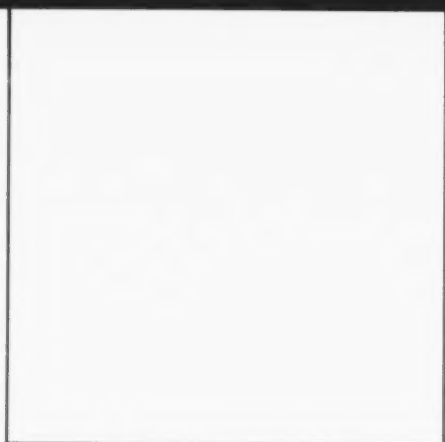
... a number of factor reduced their motivation or ability to regulate fertility: the high value attached to childbearing as a source of SS & self-esteem; the negative connotations of contraceptive use as possibly undermining M authority and promoting infidelity of the wife: limited knowledge of modern method & availability of supplies; incorrect information on the methods themselves, especially fears regarding adverse health consequences of certain methods; & limited husband-wife communication on fertility regulations.

Tsui did research on the relationship between family planning availability, rates of contraceptive use and marital fertility for women in Korea and Mexico . She noted that (Tsui, Oct. 1982, 1029)

The analysis confirms that somewhat higher rates of contraceptive use are associated with community availability of services. In general, presence vs absence of contraceptive services is the important distinction; easy accessibility of services appears to have only limited effects. Despite the association of contraceptive availability with use, recently fertility levels do not vary consistently among women at different levels of availability. This apparent anomaly may result from an insufficient lag time between the measures of contraceptive availability & marital fertility.

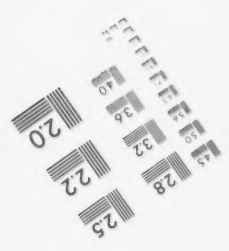


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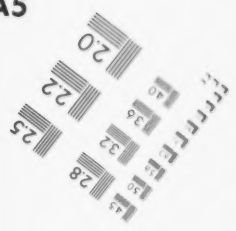


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A5



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The availability of contraceptive information rather than an ideological predisposition is viewed by Tsui as a major determinant about its usage. (Tsui, Oct. 1981)

... The multivariate analysis shows that the level of contraceptive availability directly affects the likelihood of current use, net of the effects of community development, education, parity, & marital duration. In addition, effective & persistent practice is supported in areas with high availability ... although the practice of family limitation increases with greater availability, the effects do not translate into lower birth rates for the three-year period prior to survey... Results are supportive of the recent policy emphasis on maximizing the availability of contraceptive services, especially in Ru areas of the developing world.

4. Vertical Organizations and Health Campaigns

The "centers of excellence" models developed by institutions such as the Rockefeller Foundation have helped expand the medical schools and related urban hospitals in Mexico. Special public health eradication campaigns are also the recipients of additional external support, some of which have been made available through the World Health Organization, with the support of industrialized nations (Gish, 207).

In keeping with this funding it was possible for donors to encourage, if not insist upon the creation of separate, vertical organization for - most notably - the small pox and malaria campaigns. Because external funding mostly comes in the form of

IV-28

aid to a specific project or program, as distinct from the general health services, donors feel the need for a separate, more managerial efficient, and better monitored structure than is generally to be found in the national ministry of health. However, this efficiency is often bought only at great cost both in terms of absolute monetary expenditures and, more importantly, the overall balance of health care activities within the country. In affect, relatively small sums of external assistance often become the tail wagging the dog... given the underdeveloped state of national health services and their consequent inability to carry health sector programs, the only special campaigns likely to succeed would be those based upon a technology requiring only a single application - as was the case with smallpox.

5. Women and Showmen in Medicine

The woman's status in the health field is more closely allied with that of folk-medicine than with scientific medicine. With greater access to medical resources resulting from movement away from folk-medicine, the woman's position in as an important actor in the health field might possibly decline. He notes that there is (Tousignant, 691).

The increasing importance of women in the folk medicine of southern Mexico. This change has undoubtedly resulted in part from the disintegration of organized groups of healers & the decreasing status of the profession, but structural analysis of the situation suggests an additional explanation: the healing ritual is viewed here as a process in which sexual roles are reversed. In this ritual, women assume a status which is refused to them in social life. The reversal of roles thus serves to counterbalance the overemphasis on M values in the Mexican culture.

The use of medical showmen may be a bridge between traditional and scientific medicine for Mexicans. There seems to be some potential for indigenous health providers to act as allied health personnel in the contemporary health system (Simoni, 149)

Medicine showmen prepared medicine shows focused on breastfeeding & early supplemental feeding for infants under one year of age. These shows were presented to Ru & Ur populations in the Federal District & the states of Oaxaca & Michoacan, Mexico... to measure the impact of shows on knowledge, attitudes and behavior. Reviewed is the sociological & anthropological literature related to the potential of indigenous health providers to function as allied health personnel in developing countries.

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E. CLASS-BIAS IN THE HEALTH CARE SYSTEM

The general health conditions in Mexico and the structured response to health care needs, are in need of improvement (Lopez-Acuna, 89)

With a population of almost 70 million inhabitants, Mexico, on the threshold of the eighties, still suffers from infectious diseases and the lack of sanitation. At the same time, there is an increase in chronic disease problems and conditions related to industrial damage to the environment. The social response to this pattern of health and disease is not consistent... health services are organized in a very scattered way, without coordination, hospital-based, and with very little emphasis on prevention and community services.

The capability of a systematic response to meet the health needs of the general population, is limited by the class bias of the system (Lopez-Acuna, 89)

... The Mexican health care system is built to serve the health needs of the population in reverse; the greater the need, the less is the care. The health services cater to the political, economic, social, and corporative needs of the Mexican socioeconomic formation. Particularly, medical care services have been, in postrevolutionary times, an instrument of political mediation between the State and the social demands of the population. Finally, it is clear that if 35% of the inhabitants are permanently uncovered by the health care services, the health needs of the people are being poorly met at the present time.

The Mexican health care has three components which reflect this class bias in terms of social access, financing and personnel, and hospital facilities. The following tables have been developed from information in the Lopez-Acuna article (Lopez-Acuna,)

1. <u>PUBLIC HEALTH</u> (SSA)	<u>SOCIAL CLASS ACCESS TO SERVICES</u>	<u>FINANCING, PERSONNEL</u>	<u>HOSPITAL FACILITIES</u>
	"Access to the different health services in Mexico is not equally distributed among the social classes... there are three large social groups according to the kind of health care that they receive. This comprises people that neither have a right to social security nor can afford the high prices of the private services: the peasants, the seasonal workers, the underemployed and unemployed people, that is, the majority of the assistance, including	1. The financing of the health services does not contribute to diminution of the differentials and unequally distributed resources between various Mexican populations. "... in 1977 - and this is true for the last ten years as well - the IMSS devoted to health 1.45% of GNP, or \$60 per capita, and the SSA 0.55% of GNP, or \$9 per capita. During the last decade the public investment in hospitals and health centers has actually decreased, if a comparison at constant prices is done. Furthermore, 60% of these resources have been given to the IMSS and less than 30% to the SSA (Public health) The public assistance institutions have only about 20% of the physicians and nurses.	1. 29.5% of the total beds 2. 45% of beds of the public sector 3. 39% of total facilities
2. <u>OCCUPATIONAL HEALTH</u> (IMSS)	This group comprises the industrial and urban workers affiliated with some social security institution. In 1976 only 35% of the 62 million inhabitants of Mexico were covered by the health services of the several social security institutions. That means, roughly, 22 million people, of which the IMSS covered 16 million; the ISSSTE 4 million, PEMEX 550,000; FNM 500,000; the ISSFAM 500,000, the SMN 130,000; and the CFE and SHCP 320,000 inhabitants."	The social security institutions operate on the basis of employer and employee contributions plus a certain amount received from the State and paid from general revenues. They provide services only to the people who pay the contributions and to their families. The amount given by the State to these institutions is almost the same as that paid to the SSA for covering two-thirds of the population and for organizing the public health services. The social security agencies have more than 50% of the total physicians and nurses of the country, 43% of the specialized and assistant nurses, and 82% of the other kinds of personnel.	A. For 1/3% of the population 1. 33.% of total beds of the country 2. 50% of the beds in the public sector B. 40% of all health facilities

2. <u>OCCUPATIONAL HEALTH</u> (IMSS-	<u>SOCIAL CLASS ACCESS TO SERVICES</u> In regard to agricultural workers ...Since the fifties the Instituto Mexicano del Seguro Social (IMSS) has attempted to cover some selected groups of agricultural workers, but its coverage in the rural areas is still very low. The State has concentrated its efforts on caring for the more productive sectors of Mexican society, increasing the resource allocations for the social security institutions. At the same time, resources for the health care of the nonproletarian sector have suffered decreases in the last decades. Thus, the income redistribution that could be fulfilled through the health services is minimal or nonexistent."	<u>FINANCING, PERSONNEL</u>	<u>HOSPITAL FACILITIES</u>
3. <u>PRIVATE HEALTH</u>	This group, "... includes the bourgeoisie and some sectors of the middle class than can afford private services. The coverage of the private services is hard to estimate but has no practical significance for the data on uncovered population. However, the distribution of human, material, and financial resources bears no correspondence to the population covered by the different health services.	The practice of medicine for the most part combines private and public practice. A survey carried out in 1973 demonstrated that 25% of the doctors had an exclusively private practice, 19% a public practice, and 56% a combined practice. Private institutions have between 15-25% of personnel resources for a lesser section of the population.	1. 23% of the beds 2: 15% of total facilities (other 6% of facilities to Red Cross and other institutions)

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